
**CHAPTER 1:
WASHINGTON'S
TRANSFORMATION IN
ACTION**

CHAPTER OVERVIEW

***Subcommittees
identified 27 desired
outcomes for a
transformed mental
health system***

The six goals outlined in the President's New Freedom Commission final report provide a framework for transforming Washington's mental health system. This chapter describes Washington's approach to achieving the President's goals. In addition, the Washington Transformation Work Group has added two new goals specific to Washington State relating to employment and Housing. These are addressed here as well.

For each goal, we provide the following:

- Priority outcomes identified by the TWG subcommittees,
- Strategies for implementing the priority outcomes,
- Agency partner strategic plans,
- Other MHTP transformation activities, and
- Gaps and next steps associated with the goal.

Taken together, these responses act as a roadmap, describing Washington's route to transformation. Specific implementation strategies and timelines will be developed in Year 2.

Consumers and their family members have been active partners in developing every recommendation and initiative. A detailed discussion about the process for involving consumers and their families in the initial outcome and strategy identification process was included in the Introduction.

The previous chapter provides an overview of the process used by the TWG to develop the substance in this CMHP. To briefly recap:

Seven subcommittees were appointed by the TWG to examine the strengths and weaknesses of the mental health system on specific population groups (children, youth, adults, older adults, the homeless, individuals with co-occurring disorders, and those involved in the criminal justice system). From their outreach and public input sessions, the subcommittees identified 27 priority outcomes for a transformed system.

Task Groups developed specific strategies for achieving those outcomes

Task groups then defined specific strategies for achieving those outcomes. Task groups were structured around functional areas (fiscal systems, information technology, evidence based, promising and emerging practices, cultural competence, evaluation and social marketing).

Several over-arching strategies and goals are inherent in the task group work products

In some cases, task groups were not able to be specific about strategies until additional detail became available that was not planned to be available until years 2-5 of the transformation grant activities. In lieu of, or in addition to, the specific strategies the Fiscal Systems, Information Systems and the Cultural Competence Task Groups defined principles that will guide their activities in the coming years. These principles are contained in Appendix 3.

Agency partners are actively involved in transformation

Many transformative activities are currently underway and documented in each of the agency partner's strategic plans. A summary of these plans as they relate to the goals has been included in this chapter. However, agency partners have told the Transformation Project staff that there are many activities they are involved with that are not listed in their strategic plans. The project staff plans to inventory these strategies for inclusion in next year's plan.

In addition, state agencies are currently developing budget requests and proposed legislative packages for the 2007-2009 budget period. By September, the agencies will submit these requests to the Governor's Office. Because of the need to finalize the Comprehensive Mental Health Plan by early September, these budget/legislative requests will not be included in the first year's plans. Once we know what is incorporated into the Governor's legislative package, and which items are supported by the Legislature, a more accurate gap analysis between the community recommendations and agency activities can be conducted. Once that is done, the state will have a better idea about where to focus its resources to address community priorities.

SECTION 1:
Federal New Freedom
Commission Goal #1

FEDERAL
RECOMMENDATIONS

**Reducing the
devastating effects of
stigma associated with
mental illness has
become a high priority
in
Washington State**

Subcommittee
Recommended
Outcome

**Americans Understand that Mental Health is
Essential to Overall Health.**

1.1 Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention.

1.2 Address mental health with the same urgency as physical health.

Results from Washington's Resource Inventory and Needs Assessment highlight the need for efforts designed to educate the general public and reduce the effects of stigma:

- Over half of the consumers surveyed (53%) felt stigmatized due to their mental illness,
- Half of the responding consumers (50%) believed they had been discriminated against because of their mental illness, and
- Nearly two-thirds of the respondents (62%) believe that people ignore them or take them less seriously because they have a mental illness (See Appendix 2 for the detailed report).

To combat these disturbing results, the Transformation team is partnering with the Department of Health and other agencies to initiate a social marketing campaign. This campaign is designed to reduce the stigma of mental illness, increase awareness of mental health as an essential part of health, and increase support for mentally ill individuals in the community and workplace, and is being undertaken as part of the CMHP. This initiative is described in more detail below.

The MHTP Subcommittees defined the following outcome to address Federal Goal #1. A complete list of strategies and outcomes is included in Appendix 3.

*Youth in Transition
Subcommittee*

**Task Group
Recommended
Strategies**

*Evidence-Based/
Promising/Emerging
Practices Task Group*

**Agency and Partner
Strategic Directions**

*DSHS, Aging and
Disability Services
Administration (ADSA)*

*DSHS, Division of
Vocational Rehabilitation
(DVR)*

*DSHS, Division of Alcohol
and Substance Abuse
(DASA)*

*DSHS, Health and
Recovery Services
Administration (HRSA)*

1. Reduce stigma through on-going education and training about recovery and resiliency developed by consumers and family members.

The following strategies were defined by the MHTP Task Groups in response to Presidential Goal #1.

1. Use social marketing campaigns aimed at reducing stigma. For example, *Speak Up When You're Down* is a social marketing campaign around normalizing post-partum depression responses and reducing stigma and is already funded by the Washington State Legislature.
2. Integrate center for health, mental health and life skills support (examples school health clinics).

The following objectives and supporting activities and measures related to Federal Goal #1 are defined in state agency strategic plans recently submitted to Governor Gregoire.

ADSA will continue to participate in the Co-occurring Disorders Interagency Committee with the Divisions of Alcohol and Substance Abuse and Mental Health, and co-sponsor the annual co-occurring disorders conference.

The DVR partners with the State Rehabilitation Council, State Independent Living Council, Client Assistance Program and others in the disability community to learn and respond to identified needs and issues.

Working with other state agencies, consumers, providers and local government, DASA co-sponsors an annual conference on co-occurring mental illness and chemical dependency. In addition, multiple state agencies are involved in a planning group, the Co-occurring Disorders Interagency Committee (CODIAC), which conducts cross-system planning as well as an annual conference.

The HRSA emphasizes preventive health measures and healthy lifestyle choices. Key elements of the HRSA strategic plan include:

- Retain a preventive focus in Early and Periodic Screening, Diagnosis and Treatment (EPSDT), Access to Baby and Child Dentistry, First Steps – families with children, and family planning.

*DSHS, Mental Health
Division (MHD)*

- Sustain existing state-subsidized health-care coverage for low and moderate-income children.
- Distribute evidence-based information on prevention and healthy lifestyles for clients through many different community venues, among them the Department of Health, public schools, public health districts, community clinics and libraries statewide.
- Continue efforts on reducing unintended pregnancy.
- Expand Disease Management capacity to recognize positive effects of care management on serious disease complexes.

The MHD will actively promote recovery, resiliency and the reduction of stigma for persons experiencing mental illness across the life span. Specific strategies will:

- Provide outreach and showcase of consumers' skills and abilities as a means of stigma reduction.
- Provide opportunities to allow consumers to share their stories of recovery with others.
- Develop advertisement campaigns promoting recovery and community support of persons in recovery from mental illness; consumers will be involved in the design and implementation of the campaign.
- Support working with counties and agencies to promote recovery and resilience and to reduce stigma regarding the mental health system.
- Create a recovery manual in collaboration with the Washington Institute (similar to the domestic violence manual) and distribute it throughout the mental health delivery system as a whole, including the Criminal Justice System.
- Develop triage units and create additional mental health courts wherein persons with mental illness, when possible, will be diverted from the criminal justice system and will be assessed for treatment at the onset of involvement with the state to intervene and prevent incarceration.

MHD will require that all persons experiencing mental health issues be treated with respect, understanding and compassion by:

	<ul style="list-style-type: none"> • Developing mission statements for persons working with the MHD and contract agents that incorporate the values of respect, understanding and compassion as fundamental in treatment of persons experiencing mental illness. • Working with counties and agencies to promote these values. • Adopting philosophies such as the Rochester New York Emotionally Disturbed Persons Response Team, which makes every effort to preserve the dignity of each individual encountered who is emotionally disturbed or experiencing mental illness. • Providing training for clinical providers to adhere to these minimum standards of treatment of respect, understanding and compassion.
<i>Department of Health (DOH)</i>	The state DOH is responsible for keeping Washington's citizens healthy and safe by working across agencies and with local partners. DOH's mission is to protect and improve the health of people in Washington State – mental health is part of the definition of health.
<i>Department of Veterans Affairs (WDVA)</i>	In our effort to care for vulnerable adults in our veteran homes, as well as within our Homeless Veteran and Trauma Treatment Programs, we stress the holistic nature of wellness, including the role of mental health, healthy choices, diet, exercise, smoking cessation, weight and stress management.
Transformation Grant Activities	<p>Washington's Comprehensive Mental Health Plan addresses this state's commitment to overcoming these barriers by educating the general public about mental illness, educating consumers and their families about excellent care and service options, reducing obstacles to achieving needed recovery options, and increasing the general public's understanding that mental health is only one aspect of a person's overall health and should be understood and managed on a comparable level.</p> <p>Highlighted below are a number of transformative strategies that have already begun with the support of the Mental Health Transformation Grant through its partners.</p>

**Reducing Stigma Using
Social Marketing:
A Project Framework
and Research Design**

***Who Is Working On
This?***

Washington's Social Marketing initiative will join other campaigns across the country working to change public attitudes and behavior toward mental health. This project is working to:

- Eliminate stigma and the barriers it creates in the work setting, at home, within the healthcare system and in the community, and
- Increase the understanding that people with mental illness can and do recover and live productive lives.

Health educators at the Washington State Department of Health are facilitating the social marketing aspect of the grant. They are reviewing the current literature on mental health issues as well as the transcripts and reports from the public listening sessions and subcommittees to ensure that consumer and family perspectives are reflected in the marketing plan design.

They are also convening a Social Marketing Task Group representing business, provider, consumer, family, marketing and public policy perspectives. The task group will help guide audience research decisions and help formulate the recommendations for social marketing efforts during the course of the grant funding.

The process for developing the social marketing implementation plan took place in the Spring and Summer of 2006. The work was accomplished in four phases:

Initial Planning:

- Collect available research, data and best practices
- Determine research needs and resources
- Review target audiences, segments within each audience, and characteristics that influence or determine their behavior
- Select potential target audiences and behaviors that this project will address
- Set initial goals and objectives

Formative Research:

- Conduct focus groups and interviews
- Obtain reactions to project messages, goals, objectives and potential strategies

Strategy Formation:

Program Development:

What has been Accomplished To Date?

- Test existing campaigns
- Determine baseline knowledge, attitudes and behaviors
- Review research findings and recommendations
- Select target audiences
- Develop program strategies
- Finalize social marketing strategies
- Identify and mobilize additional partners to assist with dissemination and implementation

The MHTP Social Marketing Task Group focused its initial efforts on three key groups:

- Providers of publicly funded mental health services;
- Policy makers (specifically, the Mental Health Transformation Workgroup, local elected officials, and the Joint Legislative & Executive Mental Health Task Force); and
- Consumers.

Mental health providers and policy makers are necessary participants in eliminating stigma as they are examples of what the literature refers to as “key power groups” – that is, groups that have the power to significantly affect the lives of individuals with mental illness, either positively or negatively.

Involving consumers in this effort was also considered important, as the literature indicates that contact with people with mental illness is one of three effective stigma reduction techniques.

Employers form a fourth key group. Employers have significant influence on social acceptance and reducing stigma associated with mental illness through hiring practices. Employers will be included in future phases of the social marketing initiative.

In the first year, formative research has been conducted with providers, policy makers and consumers using a combination of key informant interviews and focus groups. The intended outcome of this research was to determine which group(s) has the biggest potential impact on the elimination of stigma associated with mental illness, the most readiness to act, and what the effective strategies are to motivate action.

The Social Marketing Task Group has focused on identifying key audiences and messages in Year 1

***Future work will focus
on implementation
strategies***

**Washington is working
to establish parity in its
health delivery system
— *Washington's Mental
Health Parity Act***

The Social Marketing Task Group reviewed research findings and provided recommendations to the TWG regarding priority audiences, messages and strategies for the duration of the Mental Health Transformation Project.

The desired actions, or behavioral outcomes, for each target audience were identified and further refined by a review of the current literature.

In subsequent grant years, results of the audience research will be used to develop strategies for implementation. Potential strategies include educational activities that promote understanding that mental illness is treatable, that people with mental illness are people first and should not be defined by their illness, and that recovery is the process of developing a positive and meaningful life separate from one's psychiatric condition.

Strategies will also likely take advantage of the best practice of "contact," shown to have a deep and lasting effect on reducing stigma and breaking down stereotypes. Programs that connect consumers engaged in recovery with key power groups in the community can increase understanding about mental illness as a treatable, manageable condition and increase hope for recovery for consumers and their families.

Washington has defined a comprehensive strategy to address the financing challenges posed by the current system. For the past several legislative sessions, mental health advocates pressed diligently for the passage of legislation that would require private insurers to cover mental health services comparable to their coverage of other medical and surgical services. During the 2005 regular legislative session, the state's first Mental Health Parity Act [SHB 1154, Chapter 6, Laws of 2005] was passed and signed into law by Governor Gregoire.

The law applies to commercial health plans regulated by the Washington State Insurance Commissioner and requires employers with more than 50 employees to provide mental health care coverage. All state employee health plans offered by the Public Employees Benefits Board and Washington State Basic Health are also included. While the Mental Health Parity Act does not apply to all employer provided health care plans, the fact remains that

Gap Analysis

2005 was a landmark year for legislation related to mental health issues, and the four-year phase-in of the parity legislation will benefit many citizens of Washington affected by mental illness.

The community process has focused most of its attention on stigma reduction and suicide prevention. State agencies have identified a variety of activities related to stigma reduction and these activities will be pursued in Year 2 along with the Social Marketing Campaign. At least one state agency has a suicide prevention initiative and one of our research partners (University of Washington) also has suicide prevention initiatives. The issue of mental health being treated with the same urgency as physical health was not well-defined in our community process, nor was it addressed in agency strategic plans. There may be additional strategies agencies are pursuing that are not in their strategic plans or that are part of their 2007-2009 proposed budget/legislative packages. These packages will not be available until September.

Next Steps – Year 2-5

The Transformation Grant will partner with the TWG and research partners regarding suicide prevention initiatives in Year 2. Washington is pressing for a link between physical and mental health in State Policy and will also pursue treating mental health with the same urgency as physical health as part of a Year 2 priority.

SECTION 2:
Federal New Freedom
Commission Goal #2

FEDERAL
RECOMMENDATIONS

Consumers in
Washington voiced
concerns similar to
those raised at the
federal level

Mental Health Care is Consumer and Family
Driven.

- 2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.
- 2.2 Involve consumers and families fully in orienting the mental health system toward recovery.
- 2.3 Align relevant Federal programs to improve access and accountability for mental health services.
- 2.4 Create a Comprehensive State Mental Health Plan.
- 2.5 Protect and enhance the rights of people with mental illnesses.

During MHTP-sponsored statewide public input sessions held earlier this year, consumers and family members voiced concerns about Washington's current mental health delivery system that mirror concerns raised in the President's New Freedom Commission report.

- Choices are limited for service offerings that are flexible, customizable to the consumers' needs and accessible in all parts of the state.
- Frequently, the only services available (although not always when they were needed) include more traditional medication management and case management services.
- The system, through its policies and financing decisions, drives treatment decisions instead of the consumer and family members making decisions based on their needs.

Current policies and practices perpetuate the perception that the mental health consumer is "ill" and do not support the notions of recovery and resiliency. As a result, services that would maintain and support the integration of a consumer into the community, such as housing and employment opportunities, are not readily available.

Subcommittee Recommended Outcomes	
	<p>In response to the New Freedom Commission recommendations, the following strategies were recommended by the subcommittees to address Presidential Goal #2.</p> <p>A complete list of strategies and outcomes is included in Appendix 3.</p>
<i>Co-Occurring Disorders Subcommittee</i>	<ol style="list-style-type: none"> 1. Service Delivery is consumer driven and recovery focused. <ul style="list-style-type: none"> • There are options available outside of the current standard options such as homeopathic services.
<i>Youth in Transition Subcommittee</i>	<ol style="list-style-type: none"> 1. Consumers and family members have choices, utilize self-directed care and are sponsors, mentors and guides (i.e. peer-to-peer support). Services and supports are tailored to their cultural, community and individual needs.
<i>Adult Consumers and Families Subcommittee</i>	<ol style="list-style-type: none"> 2. Funding is attached to the consumer, allowing the consumer, with the assistance of a recovery coach, to select and self-direct services they believe will assist them in their recovery process and to purchase these services directly. All consumers have a choice of services in which they can become engaged that include at a minimum: <ol style="list-style-type: none"> a. Consumer-run services of various types, b. Individual therapy with a qualified therapist, c. Clubhouse services, and d. Case management services. 3. State regulations will be modified to allow consumer-run entities that are independent of the community mental health agencies to provide Medicaid-eligible consumer-run services. <ul style="list-style-type: none"> • Within five years, these services will represent 25% of all mental health services in Washington State, and • Within five years, 20% of adult consumers are employed as service providers in traditional mental health agencies and/or in the new consumer-run entities.

<p><i>Children/Youth & Parents/Families Subcommittee</i></p>	<ol style="list-style-type: none"> 1. Youth and family support (this includes any caregiver family including foster, adoptive and kinship families). <ul style="list-style-type: none"> • Increased parent and youth organizations, support groups, peer support and parent partners. Partnership involvement needs to be visible at all levels where youth and parents are always at the table; this includes parent/youth participation in client driven/directed services.
<p>Task Group Recommended Strategies</p>	<p>The following strategies were defined by the MHTP Task Groups in response to Presidential Goal #2.</p>
<p><i>Fiscal Task Group</i></p>	<ol style="list-style-type: none"> 1. Consumers and families should have greater responsibility/opportunity to direct services and expenditures.
<p><i>Cultural Competency Task Group</i></p>	<ol style="list-style-type: none"> 1. Identify, document, validate, implement, and support promising programs and practices that currently exist in the community. 2. Identify, implement, validate and support traditional medicines, alternative medicines and cultural traditional approaches that currently exist in the community. 3. Support efforts to document and validate emerging programs and practices and disseminate promising programs and practices statewide. 4. Provide technical assistance and support to mainstream and specialty mental health provider agencies to promote increased capacity to serve special populations, resulting in development of cultural competence teams that will provide ongoing technical assistance. <ul style="list-style-type: none"> • Provide financial and other incentives for achievement of cultural competence as demonstrated through comparable access and results from service across diverse population groups.

*Evidence-Based/
Promising/Emerging
Practices Task Group*

1. Mobilize curricula (examples: MOVE, TARGET-T).
2. Use Youth Empowerment and Engagement/life skills development curricula that includes mental health education component (examples include MOVE, TARGET-T).
3. Identify and mobilize mentors, navigators, peer advocates and other supports for family members, youth and young adults.
4. Implement a consistent statewide mechanism to ensure that the philosophy/value of family and youth involvement is taught in certification, university, and other training programs.
5. Develop a mechanism to ensure funds are available to support family and youth participation in the planning, implementation, evaluation, and policy of programs and practices (i.e., stipends, transportation, childcare, etc.).
6. Fund the development of a minimum of one independent consumer-run drop-in/resource center in each RSN.
 - These resource centers will serve as each area's umbrella organization, where trained peer counselors will assist individuals in the recovery process, including goal-setting, warmlines, developing mutual self-help groups, teaching problem-solving skills, providing vocational assistance, and developing plans for symptom management using the Wellness Recovery Action Plan (WRAP) model.
7. Fund the development of a minimum of two recovery education centers, to be run by consumers; one in Eastern Washington and one in Western Washington.
 - These centers will serve as the state's technical assistance centers offering technical assistance around consumer run services and principles of recovery.
8. Fund the development of a minimum of one clubhouse model psychiatric rehabilitation program in each RSN based on the Fountain House model.

- Free-standing clubhouse programs should be allowed to become one version of a “consumer-run entity.”
 - The definition of a clubhouse should be the definition of a clubhouse program as articulated by the International Center for Clubhouse Development (ICCD).
 - Clubhouse programs in Washington should be required to be certified by the ICCD.
 - Clubhouses should be funded in such a manner that makes it possible for the program to operate in complete fidelity to an ICCD defined clubhouse.
 - Clubhouse funding must be flexible enough to ensure that clubhouse services are consumer-directed, and that the clubhouse’s overarching focus is vocational rehabilitation and job and educational placement.
 - Clubhouses are not clinical programs – admission criteria and service planning is not based on diagnosis, level of functioning or medical necessity. Clubhouses are adjunct to clinical services and focus on people’s strengths.
9. Expand Personal Assistance Services (PAS) for people with psychiatric disabilities. PAS is a method which already has a long and successful track record for serving people with disabilities in a self-determined manner, and for which Medicaid funding is already available.
 10. Provide support for consumer-owned and operated businesses.
 11. Use peer support models such as dual recovery and double trouble.
 12. Ensure that promising family-centered processes and support services voiced as needs by communities that are not focal treatments (e.g., Youth and Family Supports/Parent Partners, including parent organizations, peer support, support organizations, parent partners, Respite Care services, Mentoring, the Wraparound process, Day treatment programs) are supported and included as options for communities.

**Agency and Partner
Strategic Directions**

*DSHS, Division of Alcohol
and Substance Abuse
(DASA)*

*DSHS, Health and
Recovery Services
Administration (HRSA)*

*DSHS, Mental Health
Division (MHD)*

13.Designate funding specifically to create/support/maintain Family and Youth Organizations and support programs.

14.Review statutory & administrative constraints to funding/reimbursement of parent/ youth partners and minimize barriers

The following objectives and supporting activities and measures related to Federal Goal #2 are defined in state agency strategic plans recently submitted to Governor Gregoire.

The DASA oversees a Citizen's Advisory Council in which two-thirds of its members are required to be consumers and/or family members, some of whom have co-occurring mental health and chemical dependency issues. The division also funds the Family Resources Institute that focuses on services to families with fetal alcohol syndrome. The institute provides support and training to family members.

In addition, DASA administers a SAMHSA "Access to Recovery" Grant that allows consumers to use a voucher system to choose the services they need, including mental health.

The HRSA plans to integrate service delivery systems by putting clients at the center of their health care and recognizing that timely attention to non-medical needs can avoid greater medical needs and costs in the future. In addition, the HRSA plans to emphasize health education, prevention and cultural competence so that clients are better equipped to pass over barriers that now limit access to primary care.

With the passage of E2SHB 1290 in 2005, the legislature strengthened the public mental health system so that people experiencing mental illness receive services focused on resilience and recovery. The bill was written to ensure that adults and children with mental illness, their families, and their advocates are intimately involved in designing mental health services that reduce unnecessary hospitalization and incarceration. The legislation is a move toward a statewide system that supports consumers to be able to live, work, learn, and participate fully in their communities. E2SHB 1290 aims for consumers to have the community and personal qualities that empower them to rebound from trauma, adversity, tragedy or other stresses and can lead productive lives.

MHPAC brings a strong consumer voice to policy and practice development

The Washington State Mental Health Planning Advisory Council (MHPAC), mandated by state and federal Law, reviews, monitors and evaluates the MHD's policies, plans and budgets. MHPAC also makes recommendations to the division about ways to strengthen the link between government decisions and consumer, family and advocate's needs and concerns. MHPAC's subcommittees include groups dedicated to the needs and concerns of children, elders, ethnic minorities, and gender preference and sexual minorities. MHPAC's membership includes a strong consumer voice, with 51% of its members representing consumers, family members and advocates. Other MHPAC members represent RSNs, service providers, and state agencies.

MHPAC's new goals are adopted from the six goals found in the New Freedom Commission's final report, *Achieving the Promise: Transforming Mental Health Care in America*.

- Consumers and family members will direct their own recovery and resilience planning, through the following activities:
 - Implement a resilience and/or recovery model whereby the consumer and their community of family or caregivers determine needs for their individual recovery and resilience plan.
 - Develop an education and training program to assist care providers (including primary care physicians) and consumers in understanding resilience and recovery to ensure consistent use of these words and meanings.
- Expand the information on Social Security (SSDI, SSI), Ticket to Work, Medicaid buy-in, and other employment opportunities for adult consumers.
- Require the integral involvement of consumers in the development of their recovery and resilience process/plans.
- Request revisions to the Revised Code of Washington (RCW) Chapters 71.24, 71.34 and 71.05 to reflect current program realities and to clearly state the rights of consumers.

- Provide training to consumers in the development of Wellness Recovery Action Planning (WRAP). Training will be offered to consumers at least annually.
- Expand information on and promote accessibility to the Social Security Administration, Medicare and other community services that promote/support older adults in maintaining optimum function and meaningful activities.
- Expand peer counseling to support consumers across the life span.
- Develop and implement concepts and programs that prioritize goals and outcomes that foster autonomy rather than maintenance and codependency.

The MHD will involve consumers, their families, caregivers, and advocates in all program design and planning of the recovery and resiliency process.

- Increase the role of consumers across the life span and families in quality management activities within MHD, state hospitals, RSNs, Community Mental Health Centers (CMHC), and CLIP via the MHPAC.
- Continue to support the efforts of the Office of Consumer Affairs.
- Showcase examples of consumer/caregiver involvement across the lifespan that demonstrate recovery, resiliency and reduction of stigma.
- Insist on consumer/caregiver presence across the life span on state hospital governing bodies and encourage presence on private hospitals governing boards, particularly where Medicaid money is utilized.
- Provide training to assist consumers and caregivers to find their own voices and tell their own stories.
- Implement a culturally competent service delivery plan.
- Provide mentoring to consumers and families prior to their membership on client/consumer committees and their attendance at stakeholder meetings.

The Mental Health Division will communicate with consumers, and ensure the sustainability of the active involvement of consumers and their advocate caregivers across the life span.

- Utilize the approved consumer self-advocacy training and Executive Order project.
- Promote consumer and caregiver advocacy to assist with legislative proposals and as a tool to influence legislation that promotes recovery and resiliency.
- Develop and train consumers as mental health system advocates in order to expand committee membership expertise.
- MHD staff meets directly with consumers and caregivers through focus groups and/or attendance at meetings.
- MHD supports and receives information from clubhouses to help programs to connect and share a common goal.

The Office of Consumer Affairs (OCA) will develop an addition to the MHD's web page that is specific to adult consumers containing frequently asked questions, definitions, resources, guides, etc. Clubhouses and consumer-run programs will be added as a resource to the MHD's web page.

- Provide training to consumers in the use of the MHD web site.
- Respond to funding and infrastructure changes in the mental health system to sustain the goal of consumer driven services.
- Develop an independent Ombudsman program to support consumer driven services.
- Work with the Joint Legislative and Executive Task Force on Mental Health Services and Financing to implement system change.
- Develop and implement a plan to monitor and evaluate the impact of system changes on consumer care at the provider level.
- Create workgroups to explore the programmatic and financial impact of changing the system structure.

- Examine current law and rule to determine by survey or assessment revisions needed to change the system structure.
- Conduct a risk management review of the system structure change.
- Study the current continuum of care to identify community alternatives to residential, crisis and inpatient capacity needs.

The growing formal network of parents and others working with the MHD has increased awareness by other programs about the benefits of bringing parents, neighbors and friends in as care resources. The mental health system has received requests for technical assistance on the best way to incorporate family and friends into the planning process to deal with children with serious emotional or behavioral needs. Although this network has become more accepted by providers as their community involvement expands, they are not yet universally seen as a resource.

This network believes strongly in their role as a system partner and will continue to be involved as coordination continues to grow. One way this coordination occurs is through the former Parent Council, supported by the MHD. The Parent Council (renamed SAFE-WA -- Statewide Action for Family Empowerment of Washington) received a SAMHSA grant to be the statewide parent/family network, and a major partner in the larger children's system grant submission. SAFE-WA has representation from all of the recognized parent advocacy and support groups in Washington and meets quarterly to bring a united voice to the division's management.

The MHD's Office of Consumer Affairs (OCA) received approval to conduct a two-year, statewide consumer and self-advocacy training program. Initiated in 2004, the ORCA (Outreach for Recovery and Consumer Advocacy) program is designed to improve the division's service delivery to consumer customers, by assisting and supporting consumers statewide. Over the course of the program, OCA staff will:

- Use surveys and focus groups to identify areas requiring improvement;
- Assist consumers in finding services and resolving problems;

*DSHS Juvenile
Rehabilitation
Administration (JRA)*

*Department of Health
(DOH)*

- Utilize provider agency consumer advisory groups for consultation and program involvement;
- Educate consumers and collect consumer voice;
- Extend reach and message of state voice;
- Include federal and regional partners in listening to views on consumer issues of interest;
- Provide public speaking and education on mental health and anti-stigma awareness. Promote values of DSHS and HRSA/MH recovery advancements;
- Process and present consumer, client and family voice. Search for success experience and recommendations;
- Retain focus that OCA's overarching mission is to assist leadership to know and value consumer insight in order to help move the system to more recovery treatment options; and
- As part of Director's Office and member of Senior Management Team, provide leadership on system evaluation and feedback; planning input; and policy and design development.

The MHD's OCA also supports the consumer network, which provides direct input to the division.

Throughout the duration of 2006-2011 strategic plan, MHD will meet with stakeholder groups for ongoing input and comment on the division's strategic plan.

The JRA is responsible for juvenile institutions, group homes, and local parole. JRA also funds county juvenile court and detention services. Their strategic plan focuses their service delivery model continuum on family involvement in the mental health treatment of youthful offenders.

The DOH strategic plan includes strategies to assure feedback from citizens. The Office of Maternal Child Health includes individuals and families as partners in shaping decisions, including a full time family consultant. The Health Systems Quality Assurance strategic plan calls for partnerships that promote the public health and customer service.

*Department of Veterans
Affairs (WDVA)*

Since 1984 WDVA has demonstrated a strong interest in creating a specialized mental health counseling program that acts to fill in the rather large gaps that exist between the war veteran with emotional and behavioral issues, and the traditionally identified services of the federal Veterans Administration (VA). Designing the War Trauma/Post-Traumatic Stress Disorder (PTSD) Outpatient Program to be family-oriented from its inception, allowing family members to receive services even before the veteran seeks out assistance. During the current global war on terror, more family members than veterans are receiving services initially. This allows the family members of deployed soldiers, sailors, and airmen, to receive care and support for the family system. As a result, families are better able to manage the pressures of a deployment and as a result are better prepared for the veteran's return.

The PTSD Program has created a network of federal, state, and private organizations and agencies to ensure the wellbeing of children of deployed and war-exposed veterans. The stress of war exposure often acts to regress development progress in children, and to interfere with social and academic progress. Attention to these issues is believed to be essential for not only the readiness of our guard members, but for the protection of our most valuable resource, the children.

In addition, Veteran Homes also are very family-oriented, from admissions through discharge or end of life support and assistance. Social and mental health considerations are always the focus in the treatment plan for residents of the Homes. Special activities tie families together in support of the wellness and care needed for the resident family member, and the continued connections offered by the non-resident family member.

**Transformation Grant
Activities**

As part of the transformation process, Washington State is exploring additional opportunities to expand consumer involvement that is appropriate and sustainable. The following are two examples of work currently underway.

Involvement at all levels of government and in the private sector is critical to transformation

— *Community Transformation Partnership (CTP)*

The Community Transformation Partnership (CTP) is a coalition of representatives from several mental health consumer, youth and family organizations who assisted in the preparation of the Washington State Transformation Grant proposal, or have expressed an interest in promoting transformation goals. The purpose of the coalition is to create an inclusive statewide structure advancing the state's mental health system transformation efforts. The Transformation Grant has supported the development of this group, but the CTP is a separate entity.

The CTP met for the first time in October 2005, and developed a charter that sets the course for future work. During the first phase of the Transformation Grant the CTP will lay the framework for policy development, education, involvement of consumers and families, evaluation, and the establishment of partnerships with transformation leaders and organizations. While the role of the CTP will evolve over time, depending on the needs of the state project team, the following objectives are examples of activities the CTP expects to accomplish.

- Provide recommendations to the TWG to ensure consumer and family participation on subcommittees and work groups.
- Assist in the development of a consumer conference.
- Assist with recruitment efforts to ensure broad consumer and family involvement in all aspects of the transformation process. This includes community meetings, subcommittees, and work groups.
- Assist in the development and implementation of transformation survey and evaluation projects to obtain consumer and family perspectives.
- Develop workshops and educational programs to widen the transformation process to include consumers and families located at the grassroots level.
- Serve as a focal point for the dissemination of information from the TWG and Transformation staff to organizations, informal networks, and individual consumers and families.

— CTP Recovery and Resiliency Seminars

The purpose of these seminars is to create broad-based recovery and resiliency awareness throughout Washington State's communities

The CTP has been meeting monthly since October 2005 to pursue these goals. Their current focus is on defining their legislative agenda and preparing and offering recovery and resiliency trainings around the state. At their retreat in June, 2006 the CTP further defined its role in forming a legislative policy strategy as stakeholder partners in promoting positive transformation in Washington State. A detailed report regarding the Community Transformation Partnership including a list of the member organizations and their representatives is included in Appendix 4.

As one of its first tasks, the CTP is developing Recovery and Resiliency training to be implemented throughout the state. These trainings are based on the Substance Abuse Mental Health Service Administration's consensus statement on Recovery and the concept of Resiliency and include the ten fundamental components of recovery (Self Direction, Individualized and Person Centered, Empowerment, Holistic, Non Linear, Strength Based, Peer Support, Respect, Responsibility, and Hope). A nationally known expert on recovery and resiliency will be brought in to conduct a "Train the Trainers" session, anticipated to occur in August 2006. Those trained will then conduct trainings throughout the state.

Initial activities will be dedicated to defining the fundamental principles in detail, and the remainder of the training activities will focus on creating a mechanism to foster advocacy and recovery support at the local level and to connect these communities to the Transformation Grant Process and statewide transformation efforts. The training is being developed by the CTP, through its Recovery and Resiliency Training subcommittee, with financial support from the Transformation Grant.

All stakeholders in the Mental Health System will be eligible to attend local sessions. The state anticipates that the seminars will result in at least three outcomes.

1. Transmit the message that mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.
2. Provide general education to providers, consumers of all ages, policy makers and other stakeholders

**Statewide Adult
Consumer Organization**

**Potential activities and
roles for the
organization are varied
and inclusive**

about Recovery/Resiliency Principles.

3. Create a mechanism to build a grass roots recovery resiliency constituency.

Washington State is in the process of forming a Statewide Adult Consumer Organization that includes a coalition of adult consumer leaders who will ultimately serve as one unified consumer voice to policy and decision-makers. This group will ensure the consumer voice becomes an integral part of the mental health service planning and delivery process.

The statewide adult consumer organization will take on a variety of roles and activities. It is expected to:

- Represent the voice of the mental health consumer and become a critical participant and stakeholder in all statewide mental health policy processes;
- Promote concepts key to the recovery of individuals diagnosed with a mental illness. These concepts include hope, personal empowerment, self-responsibility, respect, and self-determination;
- Promote consumer-established/consumer-operated services as an integral part of the mental health system of care;
- Lend critical support to self-help and mutual support groups and programs throughout the state;
- Play a key role in the development of future state strategic plans;
- Share and disseminate information;
- Provide technical assistance to affiliate groups;
- Educate public officials and the public at large on recovery;
- Link groups together to support each other in their growth and development; and
- Mobilize local communities towards transformation.

Washington has defined the following initial steps for this organization.

Step 1: Identify current or potential consumer leaders representing Washington's counties and tribes.

Step 2: Coordinate an application process to determine membership. Potential applicants will be required to complete an application containing 15 questions around recovery and wellness, self-advocacy, and team-building.

Step 3: Select eight consumers from around the state who will serve as the Selection Committee. The Selection Committee will use a standardized process of reviewing and scoring each application.

Step 4: Announce individuals chosen to serve as County/Tribal Affiliate Leads.

Step 5: Develop the structure of the organization including creating the vision and mission statements, developing bylaws, and establish a board of directors.

Step 6: Provide training in leadership, networking, grassroots organizing, and advocacy skills.

Step 7: Create subcommittees that align with planks at the 2006 Conference Summit. Work with National Self-Help Clearinghouse on identifying major areas of consensus and action steps.

Step 8: Incorporate and apply for IRS non-profit status

Statewide Action for Family Empowerment of Washington (SAFE-WA)

SAFE-WA is currently refining a database to track activities related to consumer involvement in the transformation process. Activities to be tracked are: Changes in consumer advocacy membership; changes in consumer advocacy participation; community contacts via telephone, email and U.S. Postal Service; development of a consumer volunteer base; and other activities that support the President's New Freedom Goals.

SAFE-WA in partnership with Youth 'N Action is working to form a statewide youth leadership structure. SAFE-WA is also working to engage youth participation in relevant policy boards and meeting and other activities. SAFE-WA has sponsored youth and family members to attend conferences at the state and national level. Further, SAFE-WA is conducting Evidence Based Practice and Wraparound Train-the-Trainer sessions for consumers in partnership with local community mental health and family organizations.

***College Credited
Consumer/Family
Training Program***

Gap Analysis

Plans for the next year include strengthening the infrastructure of the established organization; focusing on youth in transition; expanding youth & family organizations, building relationships with Tribes and refining details for assessing the number of youth and/or family organizations across Washington State.

Transformation Project staff are working with key stakeholders to determine the feasibility of developing a 50-credit community college consumers/family training program as part of the workforce development strategy. The project will be assessing its Year 2 strategy and will only implement programs that result in peer counseling jobs at the community mental health centers.

The three major themes related to subcommittee recommendations are having clear processes that describe how consumers and families will be involved with the development and delivery of services, that models of self-directed care be implemented, and that funding be available for consumer- and family-run organizations. More specifically, consumers and families will need to address several gaps in the current services delivery system including:

- Cost effective services are not responsive, flexible and provided in the home and in the community as a first and primary choice for consumers, youth and family members.
- Services are often not culturally responsive to consumer, youth and family member needs. This gap leads to unequal access, culturally irrelevant treatments, disproportionality and recidivism.
- Natural and community supports are not explored as a first choice.
- Services are not collaboratively developed, and integrated with formal linkages between agencies perpetuating silos in funding, access and avenues for advocacy.
- Least restrictive and most normative clinically appropriate environments are not readily available. There are too many rules and regulations that create barriers to these services and consumers, youth and family members often are not taught how to understand and navigate the systems that serve them.
- Consumers, youth and family members, cannot fully

participate in planning and delivery of services as essential partners due to the following gaps:

- Meetings are held at times when consumers, youth and family members are at work or at school;
- There is no statewide funding mechanism to compensate consumers, youth and family members for their participation (including child-care);
- Consumers, youth and family members are stigmatized by their involvement in the system instead of being recognized as having valuable expertise in the systems that serve them;
- Transportation in rural areas and food are often not provided; and
- Technical assistance is needed in reducing tokenism and building true partnership relationships based on a mutual respect and understanding.

Illustrated by the above mentioned gaps, it is clear that there are no processes currently in place that describe how consumers, family members and youth will be involved with the development and delivery of services. There is no clear access point for self-directed care interventions. Access to information regarding the latest mental health and other system related findings is not readily accessible or distributed to consumer, youth and family organizations.

Further, although state agency strategic plans do discuss (varies by agency) their proposals, much more detail is needed from each agency to determine how that agency is honoring the subcommittee recommendations.

Next Steps – Year 2-5

Agencies have told the Transformation Project staff that there are many activities they are involved with that are not listed in their strategic plans. We will inventory these strategies for inclusion in next year's plan. Also, state agencies are currently developing budget requests and proposed legislative packages for the 2007-2009 budget period. By September, the agencies will submit these requests to the Governor's Office. Because of the need to finalize the Comprehensive Mental Health Plan by early September, these budget/legislative requests will not be included in the first year's plans. Once we know what is incorporated into the Governor's legislative

package, and which items are supported by the Legislature, a more accurate gap analysis between what the community recommendations and agency activities can be conducted. Once that is done, the state will have a better idea about where to focus its resources to address community recommendations.

Throughout the project process, stakeholders around Washington expressed a desire for a system that is proactive rather than reactive. Governor Gregoire, cabinet-level executives, and members of the state Legislature also acknowledge that a transformed system will need to systematically move away from being *illness* focused towards one that is *health* focused. The strategies defined in this CMHP will drive system level changes that Washington consumers, families, youths and leaders desire.

SECTION 3:
Federal New Freedom
Commission Goal #3

FEDERAL
RECOMMENDATIONS

Washington is
committed to infusing
cultural competence
into its transformation
process

Overarching principles
for infusing cultural
competence in the
system

Disparities in Mental Health Services are
Eliminated.

3.1 Improve access to quality care that is culturally competent.

3.2 Improve access to quality care in rural and geographically remote areas.

Washington's Comprehensive Mental Health Plan addresses this state's commitment to infusing cultural competence in the transformed system by addressing barriers to treatment, increasing culturally appropriate services to all areas of the state and in all populations served, and in training and recruiting service providers that mirror the cultural make-up of the populations being served.

As part of the transformation project effort, a Cultural Competence Task Group was established to develop specific recommended strategies the state should consider in moving forward in future implementation years.

The task group identified a number of overarching principles it used to produce its strategies. In order for cultural competence to be operationalized in agencies, institutions, and communities, the following items must be incorporated into the definition of Cultural and Linguistic Competence.

1. Cultural competence is measured by the availability of sufficient numbers of duly qualified personnel and consultants for the system, to provide comparable access to and results from services provided to various communities and populations in the service area of the agency, system or community;
2. The intervention or treatment must be based on cultural values of the individual, group or groups of interest;
3. The strategies that comprise the treatment must be consistent with the values, beliefs and practices of the individual, ethnic or other cultural

<p>Task Group Recommended Strategies</p>	<p>groups of interest;</p> <ol style="list-style-type: none"> 4. Tribal nations must be given due respect for their sovereign status in selecting and receiving mental health service; and 5. Cultural competence requires a thorough understanding of the culture and language of limited English-speaking communities and also of deaf/hard of hearing, deaf/blind and other disability groups, Lesbian, Gay, Bisexual and Transgender, youth, older adults and elder communities. <p>In addition to these overarching principles, the following strategies were recommended by the task groups and approved by the TWG to address Presidential Goal #3.</p> <p>A complete list of strategies and outcomes is included in Appendix 3.</p>
<p><i>Fiscal Systems Task Group</i></p>	<ol style="list-style-type: none"> 1. Service equality should be reflected in the distribution of resources and the reimbursement for services across state. Should be a consistent array of services across regions and populations.
<p><i>Cultural Competency Task Group</i></p>	<ol style="list-style-type: none"> 1. Require participation of all mental health employees in an initial and ongoing annual training in cultural competence. 2. Recruit and hire employees and leaders that reflect the population they are responsible to serve. 3. Develop and implement a training curriculum for cultural competence in collaboration with institutions of higher education, in particular Schools of Social work and psychology, Public Health, Medicine and Law in order for students and agency personnel to become certified as specialists and future trainers. 4. Revise Washington Administrative Code or MHD-RSN contract terms to afford opportunities for minority specialists to be available to contracting agencies. 5. Create roundtables to discuss and review cultural competence issues routinely with regional service networks, Tribes, mental health providers, and state agency personnel.

*Information Technology
Task Group*

6. Identify, implement, validate and support traditional medicines, alternative medicines and cultural traditional approaches that currently exist in the community.
7. Require outreach workers for diverse communities and cultural competence specialists to become a part of the treatment team planning.
8. Provide technical assistance and support to mainstream and specialty mental health provider agencies to promote increased capacity to serve special populations, resulting in development of cultural competence teams that will provide ongoing technical assistance.
9. Provide financial and other incentives for achievement of cultural competence as demonstrated through comparable access and results from service across diverse population groups.
10. Provide social marketing methods as a means to promote and increase cultural competence awareness.
11. Promote the development of linguistically and culturally specific intake and assessment procedures.
12. Provide certified interpreters for deaf/hard of hearing and for limited to non-speaking consumers and family members that are qualified in mental health settings. Done in compliance and alignment with appropriate federal and/or state laws.
13. Develop cultural and linguistic standards and accountability measures.
14. State and local government service agencies and their contractors and Tribes will be responsible for the achievement of cultural/linguistic standards and accountability measures.
1. Develop on-line training materials. Make sure they are accessible by persons with visual disabilities, and translated into multiple languages. Training materials should include tests of what has been learned as the training progresses. Those tests should be recorded.

*Evidence-Based/
Promising/Emerging
Practices Task Group*

**Agency and Partner
Strategic Directions**

*DSHS, Division of Alcohol
and Substance Abuse
(DASA)*

*DSHS, Health and
Recovery Administration
(HRSA)*

HRSA Diversity Plan

1. Address needs of parenting youth – example Nurse-Family Partnership for all parenting youth or Young Parents Project in Miami-Dade.

The following objectives and supporting activities and measures related to Federal Goal #3 are defined in state agency strategic plans recently submitted to Governor Gregoire.

The DASA provides treatment and prevention funding to tribes, minority programs and rural communities to target underserved or hard to reach populations. A portion of the persons served have co-occurring mental illness and chemical dependency.

The HRSA strategic plans encourage cultural competence through two major efforts: the HRSA diversity plan and the Indian Policy Plan.

HRSA's goal is to build an inclusive work environment and culturally competent workforce for the 2006-2011 period. While HRSA is short of these goals today, it remains committed to improvement by both our mission and policy. The HRSA 2003-2004 Diversity Plan sets forth major goals that are aligned with performance measures in the Assistant Secretary's Performance Agreement.

The primary goal is to recruit and retain a diverse workforce by providing training for key managers and supervisors to ensure that the emerging HRSA Workforce of the future reflects the current commitment to a diverse, culturally competent staff.

A second goal is to support a continuing education environment that promotes cultural competence to the staff so that its importance is recognized in everyday accomplishments and successes.

A third goal is to integrate HRSA's diversity commitment with its business partners and other contractors. Since HRSA is not a primary provider of care a diverse provider base has a high priority because the providers are more readily visible to Medicaid communities than an HRSA staff centered in Olympia.

The HRSA Diversity Plan's final goal is to ensure no disparity of health-care outcomes between ethnic groups. This includes projects like the recent

HRSA Indian Policy Plan

outreach into urban African-American families to provide education about breast cancer issues, as well as a Department of Health's plan to recruit, train and retain more providers of diverse ethnic backgrounds. The strategy will emphasize health education, prevention and cultural competence so that clients are better equipped to pass over barriers that now limit access to primary care.

HRSA was a pioneer within DSHS in establishing a liaison and ongoing coordination with tribal governments and the American Indian Health Commission of Washington State. HRSA is committed to the Centennial Accord and recognizes its responsibility to consult with tribes on issues of mutual interest and/or concern. That effort is now embedded within the Research and Policy Analysis Division of HRSA, and the tribal liaison officer remains the primary tribal contact for HRSA.

HRSA's liaison efforts are coordinated with other tribal contacts in state government, including the DSHS Office of Indian Policy & Support Services. Washington State's medical assistance programs are formally connected with the tribes in a planning document called the "7.01 Updated Report," which is renewed every two years. It commits the administration to full cooperation with American Indians and Alaskan Natives, to share planning and problem solving, and to communicate fully on Medicaid planning and directives. The 7.01 Updated Report is prepared in response to the DSHS Policy 7.01. That policy directs each administration of DSHS to work in consultation with the federally recognized tribes and recognized American Indian organizations to develop a biennial Policy 7.01 implementation plan and annual progress reports that are specific to each region (including headquarters).

*DSHS, Mental Health
Division (MHD)*

Several significant racial and cultural disparities in services are cited in the strategic plan. In response to these trends, MHD's statewide Performance Data Group chartered a work group to examine available penetration and utilization data to determine possible reasons for these disparities.

The MHD will prioritize its renewed commitment to comply with DSHS Policy 7.01 and increase government-to-government relations with tribes. The strategic planning process must proceed sooner than time would permit for consultation. MHD anticipates consultation will occur and may result in amendments or revisions to this strategic plan. In the MHD, the regional implementation plans and annual progress reports will be submitted by the RSNs and will be specific to the RSN's Catchment area.

Throughout the duration of the 2006-2011 strategic plan, MHD will meet with the Indian Policy Advisory Council in July of each year for ongoing input and comment on the division's strategic plan.

The MHD, working with Tribes, will continue to explore and develop methods to facilitate increased government-to-government relations. This exploration continues the work of the 2003 Tribal Mental Health Summit. Currently, the MHD is investigating the use of a Tribal/Children's Long-Term Inpatient Program (CLIP) Administration Memorandum of Agreement to facilitate direct authority by Tribes to refer youth to CLIP facilities.

*Department of Health
(DOH)*

The DOH strategic plan recognizes in its goals and objectives the need to assure the health status of all people in the state, and to hire and retain a diverse complement of staff. The Community and Family Health Division includes reducing/eliminating health disparities as one element of the strategic plan. In the Office of Maternal and Child Health (MHC), reducing/eliminating health disparities is one of nine MCH priorities. The Health Systems Quality Assurance strategic plan includes strategies to: 1) Increase availability of health services in underserved communities, and 2) Increase the number and types of interventions designed to improve equal opportunity to health.

*Department of Veterans
Affairs (WDVA)*

One of the primary reasons WDVA became involved in the outpatient care of veterans with war trauma mental health needs was as a result of the lack of direct services for rural, ethnic minority, gender, and disabled veterans, and the fact that these special barriers prevented access to care. Disparities in level of care, treatment duration, and overall access continue to exist. The flood of new veterans into Washington State has required increases in our traditional efforts in these areas. This influx has prompted the creation of specialized efforts to respond when acute trauma reactions become complicated with delayed treatment, allowing substance abuse and sleep problems. When accompanied by the additional barriers of homelessness and joblessness, these take an even greater toll on WDVA clients. Removing these barriers and bringing treatment and support services to the veteran are major activities for our entire Veteran Services Division. We work at meeting the veteran where he or she is, rather than creating additional barriers. Working directly with our Washington State National Guard units and the many reserve units in our state, allows identification and referral to be done without stigma and shame for those needing help.

**Transformation Grant
Activities**

In addition to the activities being pursued as part of the CMHP, Washington State is exploring additional opportunities to address disparities in the mental health services delivery system.

*Public testimony validates
concerns that services are
lacking in rural areas
of the state*

Washington embarked on a journey to capture public testimony covering all populations in the mental health system. Responses were recorded and analyzed by research professionals from the University of Washington. In-person public testimony was supplemented by hand-written statements, email, fax, as well as additional documents received from agencies and organizations that could not be present at public input sessions. One key message heard repeatedly is that not only do consumers and providers in smaller, rural areas lack options for treatment, but these areas also receive a disproportionately small share of government funding. This limited funding further reduces the options available. As a result, consumers must often travel great distances to get to treatment centers and even then may have to

Washington is working collaboratively with Tribal Governments

travel farther to find services that actually fit their need. Equality of services and funding in all areas of the state would be an indicator of a transformed system.

Washington State has worked towards developing consistent relationships with Tribal governments within our state. A report addressing this issue in detail is included in Chapter 3.

Washington is using existing commissions to provide advice on specific populations

The MHTP project team has contacted Washington's Cultural Commissions, which fall under the direction of Governor Gregoire. The Commissions that will be actively pursued for input and advice concerning transformation activities include:

Commission on African American Affairs

The Commission on African-American Affairs which examines and defines issues pertaining to the rights and needs of African-Americans, and makes recommendations to the Governor, the legislature, and state agencies for changes in programs and laws.

Commission on Asian Pacific American Affairs

The Commission Asian Pacific American Affairs examines and defines issues pertaining to the rights and needs of Asian Americans and advises the Governor and state agencies on policies, plans and needs.

Hispanic Affairs Commission

The Hispanic Affairs Commission ensures that state programs are providing the assistance needed by the Hispanic community; advises state agencies on developing and implementing policies, plans and programs focusing on the needs of the Hispanic community.

Governor's Office on Indian Affairs

The Governor's Office of Indian Affairs, recognizing the importance of sovereignty, affirms the government-to-government relationship and principles identified in the Centennial Accord to promote and enhance tribal self-sufficiency and serves to assist the state in developing policies consistent with those principles.

Gap Analysis

The primary themes raised in the community process related to this goal are training providers to be culturally competent, ensuring equal access to services regardless of population group or geographic areas, broadening types of services available including alternative or non-traditional services, and eliminating disparities. While there are

Next Steps – Year 2-5

numerous activities being implemented to increase cultural awareness, improve cultural competences and eliminate disparities, each state agency is pursuing these objectives independent of the other.

There is a need to inventory the strategies currently in place to identify what is and is not working. It may be possible to share strategies across agencies to not only create efficiencies, but to improve effectiveness in achieving community recommendations. Because the state agencies will not release their 2007-2009 proposed budgets to the Governor until September 2006, and since agencies have not listed all of their strategies in their strategies plans, there will be a need to re-visit proposed strategies and gaps after the Comprehensive Mental Health Plan is submitted. Once that exercise is completed, the Transformation Project staff can work with state agencies to determine which strategies recommended in this report will be pursued in the next year.

SECTION 4:
Federal New Freedom
Commission Goal #4

FEDERAL
RECOMMENDATIONS

Consistent screening and
assessment processes are
needed on a statewide
level

Subcommittee
Recommended
Outcomes

Co-Occurring Disorders
Subcommittee

**Early Mental Health Screening, Assessment and
Referral to Services are Common Practice.**

- 4.1 Promote the mental health of young children.
- 4.2 Improve and expand school mental health programs.
- 4.3 Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.
- 4.4 Screen for mental disorders in primary health care, across the life span, and connect to treatment and supports.

Consumers and professionals provided significant feedback during the Year 1 of the MHTP that a lack of consistent screening and assessment tools and processes are contributing to inconsistencies in the availability and quality of services, depending on the consumer's location. This inconsistency is seen as a priority for both consumers and treatment professionals in transforming the mental health system.

In response to the New Freedom Commission recommendations, the following outcomes were recommended by the subcommittees to address Presidential Goal #4.

A complete list of strategies and outcomes is included in Appendix 3.

1. Consumers will have access to appropriate, quality treatment regardless of barriers and/or resources.
 - Services will be specific to the individual's needs.
 - There will be access to sufficient treatment providers who trained and retained.
2. Affected parties are informed, educated and knowledgeable about co-occurring disorders and their recovery culture, principles and philosophy.
 - Peer-to-peer support is available to all who want it.

	<ul style="list-style-type: none"> • Communication between and among the parties is critical to making this successful. • Law enforcement officers receive crisis intervention training to deal with co-occurring disorders.
<i>Youth in Transition Subcommittee</i>	<ol style="list-style-type: none"> 3. Increased system collaboration and service integration is prevalent across all allied systems and services. <ul style="list-style-type: none"> • Reduction in silos across system boundaries; • Increased holistic services; and • Increased cross-system treatment.
<i>Older Adult Consumers Subcommittee</i>	<ol style="list-style-type: none"> 1. Seamless, holistic care to include mental health, physical health and dental integrated for all youth 13 – 24 that provides for access on demand and includes early identification, intervention, housing, benefits and transition to adulthood. Systems use practices that have been known to work. 2. Continual quality improvement is an integral part of all systems based on feedback and involvement from youth consumers and family members. <ol style="list-style-type: none"> 1. Older Adults will have improved and consistent access to appropriate mental health services, including outreach to place of residence. 2. Appropriate mental health services for older adults are coordinated across all systems of care at state, regional and local levels.
<i>Children/Youth & Parents/Families Subcommittee</i>	<ol style="list-style-type: none"> 1. Training and Education <p>This is inclusive of partnerships that would include parents/youth and professionals as trainers, who are responsive to cultural diversity, which goes beyond linguistics and ethnicity.</p> <ul style="list-style-type: none"> • Trainings would include a basic level of information regarding mental illness and strategies and interventions about how to deal with issues as they surface. <p>Trainings would be targeted towards teachers, in an effort to help stabilize children and youth experiencing mental illness in the school environment. Trainings for parents, kinship caregivers, adoptive parents and foster parents would include behavioral intervention and crisis</p>

management skills. Other professionals also need to be trained and all trainings need to start early and include Birth to Three issues.

2. A system that is more proactive than reactive.

Serve the WHOLE family with a full continuum of community-based services, starting with prevention and early intervention. Services would be available for parents/caregivers when the child is in an out-of-home placement even though the parent may have lost their Medicaid coupon. There would be a wide range of available individualized services in the community that are supportive to families so they can keep their child at home and not give up custody so their child can get services.

Additional services in the continuum would include respite, Wraparound services, day treatment, and evidenced-based programs. They would build on family strengths and resiliencies and support parent partnering, and would be well coordinated (seamless) among the systems. Services would be available to be delivered in the family home or other community locations or family preferences.

- Revisit the Access to Care Standards and open the door to access.
- Decrease in families seeking Voluntary Placement Agreements.
- Increase in mental health treatment and community supports for parents/caregivers and their children to keep children in their homes or successfully return children to home after an out of home placement. (Children may be returning from JRA, CLIP, or CA, for example.)
- Increase in community services and supports for families. This includes respite, Wraparound services, day treatment and evidenced-based practices.

**Task Group
Recommended
Strategies**

Fiscal Task Group

*Information Technology
Task Group*

*Evidence-Based/
Promising/Emerging
Practices Task Group*

The following strategies were recommended by the task groups to address Presidential Goal #4.

1. Expand availability of early intervention and assessment for all populations.

1. Develop and pilot a consumer-focused, consumer-driven, recovery-focused needs assessment screening tool for mental health and alcohol/drugs that can be used across multiple settings.

2. Develop a website for each consumer that contains an assessment tool and its accompanying treatment goals, which can be edited as treatment progresses, and accessed if the consumer gives permission.

3. Be sure that the common screening and assessment tool include the date the service need is identified and application is made.

1. Specifically address provision of appropriate infant, toddler and early childhood mental health services.

- Statewide adoption of the DC:0-3R for children Birth through five years of age.
- Provision of appropriate relationship-based services when possible and appropriate.

2. Create a statewide Mental Health Technical Assistance, Training and Resource Center that is modeled off of the national technical assistance centers.

3. Use Depression Care Management (e.g. IMPACT, PROSPECT)

4. Implement Gatekeeper programs

5. Use the Program to Encourage Active and Rewarding Lives for Seniors

6. Geriatric Regional Assessment Team

7. Case Management

8. Elder Wrap Around

9. Expanded Community Services

10. Ensure that a specific component of the statewide training and technical assistance center

is directed at education for Primary Health Care Providers (PHCP).

- 11.Utilize models incorporating aspects of cognitive behavioral therapy and Motivational Enhancement Therapy for integrated treatment for co-occurring mental health and substance abuse disorders.
- 12.Utilize contingency management strategies to support recovery.
- 13.Utilize integrated group therapy.
- 14.Treatment for parents in particular should incorporate trauma treatment into substance treatment approaches.
- 15.Screening and treatment should deliberately inquire whether clients are parenting and how these challenges impact their parenting and family relationships.
- 16.Implement Crisis Intervention Team (CIT) model for law enforcement officials.
- 17.Use peer support models such as dual recovery and double trouble.
- 18.Integrate systematic screening for mental health and substance use.
- 19.Co-treatment oriented courts (such as Family Treatment Court, Drug Court, Mental Health Court).
- 20.Implement a statewide approach to supporting school staff to help stabilize children and youth experiencing mental illness in the school environment. Specifically consider Positive Behavioral Interventions and Supports.
- 21.Provide Co-occurring disorders training.
- 22.Provide Expanded Community Services.
- 23.Use individual placement and support.
- 24.Consumers will be required to complete their own Life Analysis, which takes the place of a professional generated Treatment Plan. The Life Analysis identifies recovery goals, and what is needed to accomplish those goals.
- 25.Restructure the Access to Care Standards to ensure treatment can easily be provided:

**Agency and Partner
Strategic Directions**

*DSHS, Aging and
Disability Services
Administration (ADSA)*

*DSHS, Division of Alcohol
and Substance Abuse
(DASA)*

- in a non-clinic setting (home, childcare center);
- to caregiver-child dyads and other family constellations;
- for disordered relationships even without a presenting primary diagnosis in the adult or child;
- for caregivers with mild to moderate mental health challenges with a specific focus on mitigating the impact of their mental health challenges on parenting;
- for children at-risk of developing severe emotional-behavioral disorders;
- for children exposed to trauma or violence regardless of presenting diagnosis; and
- for drug-exposed infants and their caregivers regardless of presenting diagnosis.

The following objectives and supporting activities and measures related to Federal Goal #4 are defined in state agency strategic plans recently submitted to Governor Gregoire.

ADSA is developing community resources for specialty services such as individuals with Traumatic Brain Injury, chemical dependency needs, mental health needs, behavioral issues and dementia. Some of this work has occurred in collaboration with other systems, including the Mental Health Division. More detailed plans will be developed over the next year.

ADSA plans to increase community services for people with mental illness and long term care needs. ADSA is also working with the Mental Health Division to ensure appropriate services are provided to ADSA clients in state psychiatric hospitals as well as planning community alternatives to state hospitals. These activities may require legislative changes, budget enhancements and Medicaid waiver revisions. Finally, ADSA is revising its assessment tool to better identify behavioral issues to improve identification of client needs.

Over the past several years, chemical dependency treatment providers have received substantial training in the screening, assessment, and treatment of patients with co-occurring mental health and

substance abuse disorders. Referrals between systems have increased, as have the opportunities to provide integrated treatment.

With the passage of Engrossed Second Substitute Senate Bill 5763 (E2SSB 5763) – the Omnibus Mental Health and Substance Abuse Treatment Act – in 2005, mental health and chemical dependency treatment providers are moving toward use of a common integrated protocol for the screening and assessment of mental health and substance abuse disorders.

DASA is undertaking a number of strategies to improve screening, assessment and referral processes.

- All treatment clients must be screened for mental health needs and services are coordinated with mental health providers as appropriate.
- All residential programs for youth and pregnant/parenting women must offer on-site mental health counseling. Also, pregnant/parenting residential programs offer parenting classes and therapeutic childcare for young children who reside in the treatment facility with their mothers.
- Chemical dependency counselors have been placed in a number of group homes to serve youth with emotional/behavioral disorders.
- Mental health counseling must be available in all residential involuntary commitment programs and secure detoxification facilities.

In addition, DASA is coordinating with the DSHS Children's Administration to co-locate chemical dependency counselors in local Children's Services offices to conduct screening, assessment, and referral to chemical dependency treatment and monitoring of treatment progress for parents involved in the child welfare system.

As part of E2SSB 5763, the Mental Health Division is required to develop an integrated and comprehensive screening and assessment process for chemical dependency, mental disorders, and co-occurring chemical dependency with mental disorders. A cross-agency team that includes MHD, DASA, DOC, and the Washington Institute for Mental

Illness Research and Training (WIMIRT) has begun implementation of this work, with input from RSNs and mental health providers. Screening tool recommendations have been established, and will be presented to interested stakeholders in August. An assessment process team, including RSN administrators, is also being assembled and will join the cross agency team to develop the assessment process.

MHD's strategic plans contain the following strategies.

- Promote the mental health of all citizens across life spectrums and ethnicity and cultures.
- Promote screening and early intervention in primary health care facilities and schools [e.g. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)] thereby actively promoting the expectation of comparable decreases in instances of mental health crisis later in life. EPSDT includes regular checkups for children to make sure they get immunizations and other preventive care needed to detect and treat health problems at an early stage
- Collaborate with other state agencies serving children and their families to provide screening for children and youth in potentially high-risk settings such as child welfare and juvenile justice settings.
- Build on service coordination and collaboration developed as part of the Children's Mental Health Initiative (Children's Administration, Juvenile Rehabilitation Administration, and Mental Health Division).
- Provide training for primary health providers to screen for and recognize early signs of emotional and behavioral problems, and to offer connections to appropriate interventions.
- Provide information, support and treatment for parents who are experiencing mental health problems to allow them to better address the needs of their children.

Improve and expand school mental health programs.

- Collaborate with other state agencies serving children and their families to address the mental health needs of children and youth in the education system.
- Develop a continuum of care to provide services and supports for children and youth in schools that includes training, prevention, early identification, early intervention, and treatment.
- Provide consistent state-level leadership and collaboration between education, general health, and mental health.

Screen for co-occurring mental and substance abuse disorders and link with integrated treatment.

- Collaborate with other state agencies serving children and youth to screen for co-occurring mental health and substance abuse disorders in the juvenile justice system.
- Collaborate with other state agencies serving children and youth to screen for co-occurring mental health and substance abuse disorders in the child welfare system (such as children in foster care).
- Identify and initiate coverage for core components of evidence based collaborative care, to include a comprehensive range of treatment modalities, i.e. clubhouses, peer counseling, respite care, and supported employment.
- Involve consumers and their caregiver advocates in program design and advocacy.
- Investigate the use of blended and braided funding to provide integrated programming.

Screen for mental disorders in primary health care, across the life span, and connect to treatment and supports.

- Identify and consider coverage for core components of evidence-based collaborative care, to include case management and disease management.
- Expand mental health services in all residential and community care settings.

*DSHS Juvenile
Rehabilitation
Administration (JRA)*

*Department of
Corrections (DOC)*

- Provide consultation to primary care providers by mental health specialists that do not involve face-to-face contact with consumers.
- Provide expanded Gatekeeper programming as an outreach to older or isolated individuals who may benefit from behavioral health screening.
- Implement a comprehensive screening process to promote early intervention and treatment for people with mental disorders, including dementia.

MHD is also involved in emergency management planning work with the Federal Emergency Management Administration (FEMA) and plays a role in planning for a statewide comprehensive response. Specific tasks assigned to the mental health system include:

- Assist in assessing the mental health needs of the population,
- Provide mental health training materials for system emergency preparedness,
- Assist in arranging training for mental health outreach worker,
- Assess the adequacy of application for federal crisis counseling grant funds,
- Address worker stress issues and needs through a variety of mechanisms, and
- Maintain a current roster of available staff that can be utilized to assist in major crisis.

JRA is responsible for juvenile institutions, group homes and local parole. JRA also funds county juvenile court and detention services. Strategic planning goals include the development of a culturally competent assessment process in conjunction with expanded, community residential-based continuum of service for youth in the justice system with mental health needs.

All offenders will be screened for their strengths, deficits and needs. Each person will have an Offender Personalized Plan that will include community risk, vocational and health needs, including mental health. Research based interventions will be implemented in the institutions that carry the most promise for creating a readiness for community re-entry. Finally, community services, including mental health

*Department of
Early Learning (DEL)*

counseling, will be focused on those services most likely to reduce re-offense rates and assist offenders in community integration.

In the 2006 Legislative Session, Washington created a new cabinet-level agency, the Department of Early Learning. Only officially in existence since July of 2006, the Department is already working with other entities to identify partners in their mission, and have assigned management-level focus on the MHTP. The Early Learning Advisory Council, with legislative and executive participation, is at the forefront of defining the agenda and includes expectations addressing child well-being. The MHTP is working to engage this important partner.

*Department of
Health (DOH)*

A major objective of the DOH strategic plan is to assure people have the information they need to prevent disease and injury, manage chronic conditions, increase healthy behaviors, and make healthy decisions. The Community and Family Health Division strategic plan calls for programs that promote a healthy start, healthy choices, and access to services.

The Office of Maternal and Child Health provides quality screening, identification, intervention and care coordination.

*Department of Veterans
Affairs (WDVA)*

The agency's focus is on the detection, treatment, and referral of veterans. Agency staff are sensitive to the special needs of veterans, and seek to support each veteran through the often difficult process of obtaining entitlement help from the federal Veterans Administration (VA). This proactive "*early is better*" approach to assessment and referral is pervasive throughout the agency's network of service officers, specialized outreach programs, Veterans Homes, and the War Trauma/PTSD Program. Since the start of the current war WDVA has been very proactive in their work with the federal VA, the Department of Defense, Washington State National Guard, and the many military reserve units all around the state. Almost every weekend, there is at least one event where on-site mental health counselors are on hand to administer standardized screening tools, to present information regarding readjustment, or to simply be available for anyone wanting to talk. The formal process often includes both screening and private interviews with the soldier and/or family member.

Gap Analysis

These meetings lead to referral via a mechanism that bypasses waiting lists and other delays. Since the agency has worked to make the links to all services to veterans seamless, a veteran can see a counselor on Saturday, and be scheduled for follow-up appointments on Monday, with either a state or federal provider, which ever is best suited to the veteran's needs.

Screening and Assessment

The analysis of agency strategic plans point to numerous gaps that need to be addressed in order for transformation to take effect. While some recent and current efforts are laudable, coordinated, uniform approaches across agencies would effectively reduce costs and create smoother access for consumers and families. Particularly with young children, careful crafting of policy to include common diagnostic standards, common treatment approaches and clarity for consumers and professionals regarding screening, assessment and treatment referral would significantly improve outcomes.

While recent legislation has established a common screening and assessment approach across the addiction and mental health systems, not all agencies are using standardized instruments for screening and assessment. Some agencies are advancing the use of standard screening, but there is a lack of clarity regarding the services that would be indicated through screening programs. Schools, child care systems and the child welfare agency would benefit from standardized models for referral and care. Referral policies vary across these systems and there is confusion regarding eligibility. When the treatment of children with emotional disturbance requires services for their parents, the systems often break down attempting to determine which agency or service system is responsible.

Access to Care Standards

The state's Access to Care Standards are established to determine eligibility for the current RSN service structure and focus heavily on current clinical diagnoses (e.g., Diagnostic and Statistical Manual 4), often keeping Medicaid eligible individuals from accessing appropriate, early care. Children and families are often caught in a vicious circle, where Medicaid eligibility is established, but no clear care system is available for referral. Medicaid eligible children and their families have no service structure through the RSN structure that will pay for needed

<i>School Systems</i>	<p>services. Primary care will provide assessment, but no provider service system is available that can be reimbursed through Medicaid.</p>
<i>Prevention/Early Intervention</i>	<p>State public education systems have fragmented mental health service strategies, dependent largely on the innovation of individual districts rather than a state policy for mental health care. The state's recent creation of the Department of Early Learning and the Washington Learns Initiative are promising opportunities to improve school mental health service, but a consistent set of policies is yet to emerge.</p> <p>Prevention programs in Washington State are fragmented, un-coordinated and tend to focus on specific issues/populations without regard for public health science that recognizes common risk and protective factors. While individual programs are excellent and well designed, mental health is often absent from the ongoing collaboration between the key players. The Transformation Project has brought together prevention experts from across disciplines (See Chapter 4 - <i>Prevention</i>) but significant work is required to begin crafting a statewide, multidisciplinary approach that brings mental health into focus</p>
Next Steps – Year 2-5	<p>During Years 2 -5 the Transformation Project will focus on several priority activities related to Goal #4 include:</p> <ul style="list-style-type: none"> • Promoting the current effort to standardize screening/assessment processes, • Continuing development of effective school based policies, • Partnering with schools, early learning, child care and child welfare efforts, • Continuing development of a state prevention policy, and • Continuing development and assessment of strategies that cross the life span.

SECTION 5:
Federal New Freedom
Commission Goal #5

FEDERAL
RECOMMENDATIONS

**Washington’s strategy
for defining practices
and research priorities
is inclusive of partners
at all levels of the
delivery continuum**

Subcommittee
Recommended
Outcomes

**Excellent Mental Health Care Is Delivered and
Research Is Accelerated.**

5.1 Accelerate research to promote recovery and resilience, and ultimately to cure and prevent mental illnesses.

5.2 Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation.

5.3 Improve and expand the workforce providing evidence-based mental health services and supports.

5.4 Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.

Washington has defined a clear strategy for ensuring practices that best meet consumer needs are pursued. In tandem with these strategies, the MHTP is increasing research efforts that effectively target services that provide consumers the most effective options. The MHTP is ensuring consumers, advocates, clinicians, administrators, and researchers are fully engaged in the transformation process through the Evidence-Based, Promising and Emerging Practices (EBPEP) Task Group.

The EBPEP task group defined the scope of strategies in the most inclusive way possible, consistent with the scope of the project. Informed by the evolution of the concept of evidence-based practice in the scientific literature and the philosophy developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) the types of strategies included in the task groups’ efforts target three types of practices (evidence based, promising, and emerging) and more general system strategies.

In response to the New Freedom Commission recommendations, the following outcomes were recommended by the subcommittees to address Presidential Goal #5.

	<p>A complete list of strategies and outcomes is included in Appendix 3.</p>
<i>Criminal Justice Subcommittee</i>	<ol style="list-style-type: none"> 1. Decrease the number of people with mental illness from entering into the criminal justice system. 2. Increase access to mental health and substance abuse services for those within the criminal justice system. 3. Decrease the number of people with mental health illness re-entering the criminal justice system
<i>Co-Occurring Disorders Subcommittee</i>	<ol style="list-style-type: none"> 1. Affected parties are informed, educated and knowledgeable about co-occurring disorders and their recovery culture, principles and philosophy. <ul style="list-style-type: none"> – Peer-to-peer support is available to all who want it. – Communication between and among the parties is critical to making this successful. – Law enforcement officers receive crisis intervention training to deal with co-occurring disorders
<i>Youth in Transition Subcommittee</i>	<ol style="list-style-type: none"> 1. Consistent access to quality services and supports available regardless of location or funding sources.
<i>Adult Consumers and Families Subcommittee</i>	<ol style="list-style-type: none"> 1. The ombuds system is independent of the mental health system (MHD, RSNs, and provider agencies). 2. Everyone working in the mental health system is trained and certified in psychiatric rehabilitation through college programs specially designed to provide such training. All recipients of services are also trained in psychiatric rehabilitation.
<i>Older Adult Consumers Subcommittee</i>	<ol style="list-style-type: none"> 1. Mental Health services for older adults will be provided and funded in an integrated holistic model of care including mental health, medical, substance abuse, social services and spiritual. 2. There will be an increased number of service providing individuals with professional experience in mental health and aging.
<i>Homelessness subcommittee</i>	<ol style="list-style-type: none"> 1. Services are available immediately, regardless of the financial or categorical status of the individual or family, while other benefits and services are

<p><i>Children/Youth & Parents/Families Subcommittee</i></p>	<p>being applied for.</p> <ol style="list-style-type: none"> 2. Housing will be available immediately upon need for individuals/families. 3. Continuation of services after a person has passed the crisis or transitional point (to avoid services and/or housing ending after a person is stable, decompensating back into homelessness).
<p>Task Group Recommended Strategies</p> <p><i>Fiscal Task Group</i></p>	<ol style="list-style-type: none"> 1. Greater availability of state-only funds. <p>This would require a decrease in requirements around State-only funds and an increase in the flexible use of these funds. With that in place we would purchase with:</p> <ul style="list-style-type: none"> • State-only funds for parent organizations, mentorships; • State-only funds to serve those who are not in the country legally, non-Medicaid children/youth and families; and • State-only funds to serve working poor and people who have exhausted their insurance benefits
<p><i>Cultural Competency Task Group</i></p>	<p>The following strategies were defined by the MHTP Task Groups in response to Presidential Goal #5.</p> <ol style="list-style-type: none"> 1. Seek to reduce funding silos and increase/expand integration of funding streams; seek waivers to expand integration. 2. Reimbursement should be outcome based with incentives for adopting evidence-based practices.
<p><i>Information Technology Task Group</i></p>	<ol style="list-style-type: none"> 1. Support efforts to document and validate emerging programs and practices and disseminate promising programs and practices statewide. 2. Identify, document, validate implement, and support promising programs and practices that currently exist in the community. 3. Publish reports, whenever possible, that distinguish outcomes by subgroup – demographic, ethnic, geographic. <ol style="list-style-type: none"> 1. Expand existing cross-agency outcome database to each consumer receiving public or charity funded health, mental health or alcohol/drug services from any local or state agency, jail,

prison or hospital.

- Include outcomes drawn from public records of important life and recovery issues (such as employments, arrests, graduations, hospitalizations, and marriages).
 - Develop and pilot consistent survey measures for those outcomes that cannot be gathered from existing agency records.
2. Use Outcome Database, adjusted for differences between treatment and comparison groups using the assessment and diagnostic information.
 - Publish reports, whenever possible, that distinguish outcomes by subgroup – demographic, ethnic, and geographic.
 3. Use Outcome Database to monitor client outcomes resulting from services received from various mental health and AOD treatment providers. Adjust for differences in populations served using the assessment and diagnostic information from Strategy 5.
 4. Develop a training and quality assurance database on selected evidenced-based practices.
 5. Cost out various alternatives for charging services; choose one and implement it.
 6. Require consumer-run services to enter persons served, frequency and dates of services. Best method might be a website using an ID card, or a web-accessible database.
 7. Develop maps and directories of service providers by specialty area. Include the private providers. Generate lists from licensing databases, expanded 911 lines, crisis and referral databases and other frequently updated directors. Allow providers to self-refer to the lists, with references.

*Evidence-Based/
Promising/Emerging
Practices Task Group*

1. Develop mechanism for supporting relationship development maintenance between incarcerated parents and their children (e.g., TAMAR's children model).
2. The MHD will pilot two self-directed care programs, one in Eastern Washington and one in Western Washington, based on the Florida SDC Model.
 - Consumers in this program will be paired with a trained life coach who will act as a brokerage support to assist in the overall design and management of their self-directed care plans.
 - Consumers in this program will be eligible to purchase services for the purpose of accessing:
 - Clinical Recovery Services,
 - Psychological Assessment,
 - Medical Services (Psychiatric Evaluation, Medication Management),
 - PACT,
 - Individual and Group Therapy provided by a licensed mental health professional, and
 - Supported Employment.
 - Recovery support services (services that are alternative to traditional mental health services) such as:
 - Massage therapy as a form of touch therapy to assist an individual overcome issues documented by a licensed mental health professional;
 - Forms of art therapy;
 - Smoking cessation activities
 - Occupational, speech, and physical therapy when recommended by a licensed mental health professional; and
 - Services related to developing employability and/or productivity that will lead to employability.

- Recovery enhancements (tangible items for consumption that relate to employment or other productivity such as volunteer work or training/education) including:
 - Transportation,
 - Non-cosmetic dental work,
 - Hearing aids,
 - Non-cosmetic eye glasses and non-disposable contacts, and
 - Other specific enhancements that relate to employment and productivity in consumers' communities are enumerated in the Task Groups report.
 - Consumers will be provided comprehensive informational supports about medication assistance, treatment options, and potential providers.
 - Consumers will be encouraged to complete an Advance Directive; Relapse Prevention Plan; Crisis Plan; Personal Safety Plan; and Post Crisis Plan. The goal is for participants to take control of their own lives, and not be controlled by their illness, circumstances, or others.
3. Increase Wraparound services with a specified model that includes quality monitoring.
 4. Adopt a comprehensive collaborative mental health-juvenile justice strategy for intervening at critical points in juvenile justice processing (initial contact, intake, detention, judicial processing, placement, probation, aftercare).
 5. Perform mental health screening and assessment routinely as youths move from point to point in the juvenile justice system.
 6. Provide evidence-based treatment models while within the juvenile justice system.
 7. Jointly establish procedures and policies for identifying youth who are appropriate for diversion.
 8. Institute and evaluate diversion mechanisms at every key decision-making point within the

- juvenile justice continuum.
9. Provide Crisis Intervention Training to Police Officers.
 10. Arrange for continued access to evidence-based care upon release including models such as Multi Systemic Therapy, Functional Family Therapy, and Family Integrated Transitions.
 11. Use Life skills development curricula that includes mental health education component (examples include MOVE, TARGET-T).
 12. Use navigators and peer advocates.
 13. Integrate centers for health, mental health and life skills support (example school health clinics).
 14. Use Transition centers.
 15. Address needs of parenting youth – example Nurse-Family Partnership for all parenting youth or Young Parents Project in Miami-Dade.
 16. Use Empowerment and Engagement curricula (examples MOVE, TARGET-T).
 17. Develop institutionalized consumer advisory boards.
 18. Depression Care Management (e.g. IMPACT, PROSPECT).
 19. Include inquiry into provision of care giving to children.
 20. Continue Geriatric Mental Health Specialty Training.
 21. Provide co-occurring disorders training.
 22. Implement a consistent statewide approach to ensuring that family mental health supports are available for all family members (Birth on up) during both periods of homelessness and transition.
 23. Use multi-disciplinary teams including mental health and chemical dependency specialists, RN/ARNP, case managers, and peer supports are available at drop in centers and shelters to provide assessment, services and supports.
 24. Make available Medical Respite for youth and young adults.

25. Make needed mental health and general community support services immediately available to those requiring assistance in process of stabilizing while entitlements are pursued.
26. Implement PACT teams.
27. Establish a medication initiation and maintenance service that can be quickly and easily accessed by people without Medicaid or those with Medicaid who have not been able to get enrolled in community mental health services.
28. Create an ample supply of outreach and engagement teams aimed at identifying, engaging and stabilizing homeless persons with mental disorders.
29. Programs are developed for youth and young adults that are developmentally appropriate and meet the unique, individualized needs of this population. Such models should include access to and availability of comprehensive support services including mental health, substance abuse, independent living skills, and vocational training are provided to assist youth and young adults in maintaining housing (Local examples – Youth Care Model, Mockingbird Family Model programs).
30. Develop a statewide Youth and Family Engagement Academy to mobilize funding, develop training, and match family and/or youth involvement models to community needs.
31. Establish Housing First: Large investment in development of enough permanent subsidized housing to meet the needs of all homeless people with mental illness. Appropriate supportive services need to be attached to housing.
32. Establish some transitional housing options to provide for overflow need.
33. Use 4-year and 2-year colleges to train professionals and para-professionals in psychiatric rehabilitation.
34. Encourage reinstatement of psychiatric rehabilitation programs at Washington State University and in the Eastern Washington University Social Work departments and in additional undergraduate schools.

35. Develop certificate and AA programs at community colleges in alignment with USpra program requirements.
36. Establish a Recovery Education Center School that would be licensed by the State of Washington (e.g., college degree in behavioral health recovery).
37. Establish Recovery Schools as a post-secondary educational institution.
38. Identify early childhood aggression and implement evidence-based practices around responding to early childhood aggression and conduct problems (e.g., the Incredible Years program).
39. Work with the schools to increase early identification of emerging aggression, conduct problems, and delinquency and implement evidence-based interventions.
40. Establish treatment courts and court-based interventions for youth and parents/caregivers with MH or SA disorders resulting in child abuse or neglect. (e.g. Family Treatment/ Dependency Court, or the Miami-Dade Infant Mental Health Court).
41. Establish treatment courts and court-based interventions for adult offenders with mental illness.
42. Establish local Triage Centers.
43. Undertake a comprehensive, cross-system financing strategy for child, youth, and family mental health that aims to maximize federal entitlements, increase flexibility, and fit state-only funds to state and local needs.
44. Collaborate with Insurance Commissioner around options for ensuring EBTs are reimbursable through private insurance plans.
45. Ensure that a specific component of the statewide training and technical assistance center is directed at education for Primary Health Care Providers (PHCP).
46. Implement a statewide approach to supporting school staff to help stabilize children and youth

**Agency and Partner
Strategic Directions**

*DSHS, Division of Alcohol
and Substance Abuse
(DASA)*

experiencing mental illness in the school environment. Specifically consider Positive Behavioral Interventions and Supports (PBIS).

47. Cross train DVR staff and clinical and vocational mental health staff to increase integration and communication.

48. Treatment of parents in particular should incorporate trauma treatment into substance-treatment options.

49. Screening and treatment should deliberately inquire into if clients are parenting and how these challenges impact their parenting and family relationships.

50. Create an Evidence-Based/ Promising/Emerging Practice (EBPEP) Institute to provide mechanisms to:

- Provide oversight and direction toward the implementation of EBPs including consumers, parents, and youth;
- Review, monitor, and disseminate information on evidence-based practices and current research;
- Assist communities to identify local needs, select evidence-based approaches and provide technical assistance for implementation; and
- Evaluate and maintain strategies including evaluating current and new practices and monitoring for fidelity and outcomes.

The following objectives and supporting activities and measures related to Federal Goal #2 are defined in state agency strategic plans recently submitted to Governor Gregoire.

The DSHS Division of Alcohol and Substance Abuse (DASA) conducts extensive evaluation and research projects. Some of these projects have explored whether clients with co-occurring disorders have equal or worse outcomes than those with chemical dependency only. More of this research will be conducted in the future as evidence based practices for co-occurring populations are implemented.

Washington Medicaid
Integration Project
(WMIP)

DSHS implemented an initial pilot project of WMIP in Snohomish County in the fall of 2004 to provide integrated medical, behavioral health and long-term care services for approximately 6,000 aged, blind and disabled clients. Medicaid clients who voluntarily join the project have benefited by a “medical home” in the provider network furnished by the managed care vendor contracted to integrate current services (including drug and alcohol treatment, mental health care, and medical services).

HRSA is also the lead administration in the Medicaid Integration Partnership, an effort that brings together all of the Medicaid funding streams in DSHS to create a new delivery model that is client-centered and efficient. Participating administrations include Aging and Disability Services Administration (long-term care) and DSHS’s Division of Research and Data Analysis.

General Assistance –
Unemployable
Managed Care Pilot

HRSA is currently setting up a pilot project in King and Pierce counties (the state’s largest urban population) to deliver health care services to persons eligible for general assistance through DSHS. This population is often characterized by the existence of mental illness and homelessness. The pilot project is being designed to:

- Maximize care coordination, high-risk medical management and chronic care management,
- Improve our citizens’ health by purchasing evidence-based health services,
- Establish evidence-based decision-making processes that will increase the explicit use of current best practices in making care decisions,
- Establish incentives for providers, using evidence-based health promotion and disease prevention programs,
- Increase educational opportunities for providers on the evidence-based process and how to access information to support their decisions, and
- Establish a process to determine which benefits and related scope are most likely to improve and maintain the health status of HRSA clients in an efficient manner.

*DSHS, Mental Health
Division (MHD)*

Two recent pieces of legislation are supporting the MHD's strategic planning process. Engrossed Second Substitute House Bill (E2SHB) 1290, passed in 2005, promotes public policy focused on mental health treatments and services that are evidence and research-based [meaning they are programs or practices that have demonstrated results in clinical trials or have some research demonstrating effectiveness but do not yet meet the standards of evidence-based practices (EBPs)]. The legislation also aims to ensure public mental health services are delivered efficiently, effectively, and consistently across the state. Coordination of services within the department is emphasized and includes partners outside of DSHS such as the Office of Superintendent for Public Instruction, state mental hospitals, county authorities, community mental health providers, and other support services. Such coordination will also include families and advocates of persons with mental illness to the greatest extent possible.

Crisis Response Pilots

Engrossed Second Substitute Senate Bill (E2SSB) 5763, also passed in 2005, integrates treatment of co-occurring mental and substance disorders to achieve successful outcomes and recovery. The bill also directed DSHS to contract for two pilot sites (one urban and one rural) to test changes to the chemical dependency involuntary treatment law. The pilots will integrate mental health and chemical dependency crisis response, and allow for 72-hour detention and 14-day commitment into a secure detoxification facility.

The department invited all counties in the state to submit proposals for the Integrated Crisis Response Pilots. Two successful bidders were chosen and became operational March 1, 2006: Pierce County and the counties that make up the North Sound RSN. MHD and DASA have developed contracts for the services and a training curriculum for the designated crisis responders.

*Children's Mental Health
Initiative*

In December 2003, the Assistant Secretaries for Children's Administration (CA), the Health and Recovery Services Administration (formerly Health and Rehabilitative Services Administration), and the Juvenile Rehabilitation Administration (JRA) convened a work group to address the mental health needs of children and youth who are served by these

three systems within DSHS. The DSHS Children's Mental Health Workgroup published a report in July 2004. Two significant themes that received attention both within the Workgroup and from stakeholders were the dynamic tension between statewide consistency and local discretion, and a perceived gulf between family-driven, culturally appropriate services and EBPs.

The Workgroup set forth several recommendations that addressed these tensions:

- Implement evidence-based care statewide and develop a common approach for the provision of mental health services for consumers across the life spectrum using evidence-based practices.
- Work with MHPAC on evidence-based practices (EBPs) and promising practices to identify needs and barriers to EBP implementation. Develop clear funding streams and start up costs associated with each EBP.
- Develop requests for legislation to solicit on-going funding for EBPs not covered by Medicaid.
- Provide training and technical assistance and follow-up to sites implementing currently defined EBPs.
- Develop policies and monitoring strategies for EBPs (to include fidelity assessments, incentives, increased monitoring of consumer outcomes, and a process for incorporation of new EBPs).
- Develop reporting guidelines for EBPs.
- Showcase MH agencies with effective EBPs.
- Collaborate with other DSHS agencies to implement cross-system EBPs.
- Provide training, technical assistance for evaluation, and follow-up of new promising and innovative practices.
- Continue review of clinical practices, with inclusion of promising practices as they become supported by evaluation and consumer outcomes.
- Meet with SAFE-WA to discuss and receive input with regard to the best approaches for including families and youth in the provision of services.

- Meet with Health Action to discuss and receive input with regard to the best approaches for including youth in the provision and development of services to youth.
- Support the increased involvement of youth in system development.
- Track the progress of joint strategies developed with other administrations and divisions.

Develop an information system that integrates quantitative and qualitative data across the mental health system and facilitates access to reports.

- Build on existing information systems to incorporate and integrate computerized data from Quality Assurance and Improvement (QA&I) reviews.
- Build on existing information systems to incorporate and integrate other qualitative data (e.g. OCA, QA&I, Ombudsmen, and P&P).
- Better integrate information systems throughout DSHS to better identify older adults service needs for the development of more specific outcome measures.

Use performance indicator reporting to manage and improve the mental health system through contracts and quality improvement efforts.

- Develop Performance Indicators from the consumer outcome system.
- Develop Performance Indicators that are specific to older adult issues.
- Develop consensus within MHD about goals/benchmarks for these performance indicators.
- Maintain involvement in national performance indicator efforts through CMHS, NASMHPD, ACMHA, NCQA, and JCAHO.
- Develop positive incentive system for RSNs following JLARC recommendations.
- Develop system to recognize programs/providers/RSNs that exceed expectations or demonstrate best practices.

Children's Mental Health
Pilot Project

RSNs/PIHPs are implementing protocols for service delivery for the provision of services to children and youth who receive services through cross-system initiatives. These protocols were designed with the assistance of care providers, parents and other concerned citizens. RSNs/PIHPs have been involved in the design of the services for hard-to-place adolescents and they have been involved with the DSHS Children's Mental Health Workgroup discussed above.

The Mental Health Division received funding to establish a pilot program to provide evidence-based mental health services to children. In collaboration with the JRA, MHD will be preparing a request for proposal to solicit bids from potential contractors. The department, in consultation with a broadly representative group of individuals with expertise in children's mental health, will establish a list of evidence-based mental health services that the pilot sites can choose to provide. The project will require significant collaboration between all of MHD's service partners including agencies and community partners. In addition, the University of Washington will provide expertise in all phases of the project including pilot initiation, implementation, training, quality assurance and monitoring implementation and outcomes. The pilot sites are planning to become operational in December 2006.

*Co-Occurring Disorders
Interagency Committee*

The MHD and the Division of Alcohol and Substance Abuse staff the Co-Occurring Disorders Interagency Committee (CODIAC), a committee of providers from mental health, chemical dependency, other cross-systems and consumers. This group has been in existence for approximately 12 years and addresses co-occurring mental illness and substance-related disorders. The two divisions often engage in joint studies and are currently developing a joint demonstration project serving persons with co-occurring disorders in Yakima.

NIMH Planning Grant

The Mental Health Division received a National Institute of Mental Health (NIMH) planning grant in 2003 and was able to create both internal and external work groups to look at issues related to the implementation of evidence-based practices. A subcommittee of MHPAC has been tasked with development of a work plan to guide further efforts.

*DSHS Juvenile
Rehabilitation
Administration (JRA)*

The work plan includes:

- Disseminating the practices and training providers on their use;
- Identifying barriers to implementation statewide (e.g., funding, licensing, monitoring, and oversight);
- Creating a process for reviewing and selecting new EBPs and promising practices; and
- Hosting a conference highlighting the Committee's work.

As part of MHPAC's activities, an internal work group to coordinate EBP efforts across the MHD (Assertive Community Treatment-ACT, Dialectical Behavioral Therapy-DBT, and family psycho-education), DASA (integrated COD services), Child Welfare (Wraparound and therapeutic foster care services), Juvenile Justice, and the Health and Recovery Services Administration (medication algorithms).

JRA is responsible for juvenile institutions, group homes and local parole. JRA also funds county juvenile court and detention services. JRA has long been the provider of last resort for adolescents whose mental health and addiction problems lead to criminal offenses. With a lack of community-based services for youth, JRA provides a variety of efforts both in institutions and at the community level to prevent deeper penetration into the justice system. An early adopter of evidence-based practice, JRA continues to expand its programming efforts. The new JRA Mental Health System Design will establish acute care, extended care, and mainstream mental health treatment units in JRA residential facilities. Their strategic plan also calls on the agency to develop and sustain quality control/adherence standards to assure fidelity to evidence-based treatment modalities and practices delivered with JRA's Integrated Treatment Model (ITM). JRA will maintain a strong continuum of care for juveniles, delivering evidence-based treatment interventions that encourages and facilitates active family involvement, and promotes successful community reintegration. JRA was the first juvenile system to integrate chemical dependency treatment services throughout the continuum, and has specialized services, coordination and management devoted to

*Department of Health
(DOH)*

both addiction and mental health problems for youth in their care.

The DOH strategic plan contains multiple components toward quality of care, including data and quality assurance management practices. The public health model adopted by the Department relies on epidemiology and scientific research to guide management practices. To assure that public health interventions are designed using the best available evidence, and that Public Health Standards are followed.

*Department of Veterans
Affairs (WDVA)*

All care offered within the War Trauma/PTSD Outpatient Program undergoes several levels of assessment and guidance. The network of providers works to ensure that best practices are employed, and that outcomes meet the expectations of the program. Clients are surveyed in a variety of ways, from customer satisfaction surveys, symptom change assessments, to longitudinal outcome assessment using standardized tools. At all levels from point of referral to time of intake, to the full duration of treatment, clients are informed and offer opportunities to provide input regarding the quality, effectiveness, type, duration, and expectations of treatment. All providers are held to the highest of standards for care, and must pass audits of care and site visits. Quality of care is appraised in several ways, allowing for lowered risk concerns and offering the latest in treatment advances. Frequent training events and conferences allow contractors access to PTSD and other treatment literature and consultation resources.

*Office of the
Superintendent of Public
Instruction
(OSPI)*

As the lead state educational office, OSPI funds basic education through 243 school districts. A number of coordinated efforts exist locally to provide mental health services. However, there is work remaining to instill the principles of consumer involvement and recovery/resiliency into the educational system. There are two particularly significant developments in Washington State that create opportunities to advance Transformation: Washington Learns, a joint Executive/Legislative body co-chaired by Governor Gregoire and Superintendent Terry Bergeson; and, the newly created Department of Early Learning. Both bodies will be critical to the success of transformation.

**Transformation Grant
Activities**

**A strategic Research
Partnership will bridge
the gap between
research, policy and
practice**

Additionally, Chapter 4, *Prevention* describes some of the work required to better understand issues regarding pre-school and school-aged children.

The OSPI five-year strategic plan includes a strategy aligned with the Presidents goal #5: improving collaboration with the Department of Social and Health Services and other child serving agencies to improve access to care for children in school. The OSPI also aligns with this goal in a number of important programs, such as chemical dependency and prevention coordination efforts, and Readiness to Learn, a school based program to improve child well-being.

In addition to the activities being pursued as part of the CMHP, Washington State is exploring additional opportunities to address disparities in the mental health services delivery system.

Mental health policy development in Washington state has historically been somewhat fragmented. As is typical in a complex public policy arena, little crossover has traditionally existed between the research coming out of the academic community and the policies and practices pursued by policymakers and the service provider community. More often than not, key players have competed, rather than collaborated, for limited funding and innovation opportunities.

The MHTP is working to change that with the creation of the informal Research Advisory Group. On a quarterly basis, the MHTP brings together university researchers and state agencies to talk about the critical needs and how to make the most of the resources available. The Research Advisory Group is designed to provide a forum for discussing practical solutions to real world problems, through the application of science-based research.

Researchers are encouraged to collaborate with each other and with state agencies on projects, and strategic partnerships are developed for joint bids on grants and other funding opportunities.

The Research Advisory Group bridges the gulf between scientific research and practical applications by encouraging new collaboration and partnerships across organizations and disciplines, all with the intent of focusing the considerable wealth of knowledge and expertise to develop new empirically

Local law enforcement entities are convening a summit to examine policies and implications of mental health practice

based and tested approaches to mental health services. In Year 2 of the grant, local government, providers, tribes and consumers/families will be invited to participate.

The Washington Association of Sheriff's and Police Chief's (WASPC), with support from the Project, will conduct a policy summit in September of 2006. The agenda for the summit is examining the policy and implications for practice pertaining to consumers in local jails. The Transformation process often identified problems associated with mentally ill individuals held in jails. Local jails are often in the position of responding to and containing consumers in crisis. On most occasions, some criminal activity is involved, but statistics bear out that individuals with mental health problems spend more time in jail than non-mentally ill individuals.

The summit planning group envisions an opportunity to bring policy makers together to discuss solutions. A variety of strategies emerged in the process conducted by the Project, including Crisis Intervention Training for police officers, triage centers and better service relationships between mental health providers and jails. The audience for the summit will be state and local officials in law enforcement, justice and treatment as well as elected officials at both the state and local level. The anticipated outcome of the summit will be a set of policy initiatives to address the issue of mental health and substance abuse services and jails.

**Next Steps – Year 2-5
Gap Analysis**

Many of the Subcommittees recommendations proposed that new practices be implemented, in some cases to extend existing services, and in some cases to supplant existing services. Many of the practices requested do not meet objective criteria as being "evidence-based," and the EBP Task Group expanded its scope to include a number of practices consistent with subcommittee recommendations.

A review of recommendations from the Subcommittees and the Task Groups and the State strategic plans reveals a wide diversity in approaches. State agencies are planning to ensure that excellent mental health care is delivered and research is accelerated. The review suggests that a great deal of what has been recommended is indeed identifiable in strategic plans. However, many of the recommendations are broad and general, and some of the content of the strategic plans are written without enough specificity to determine the overlap or alternatively, a lack of congruence.

Generally, most of the Transformation recommendations achieve at least some mention in the strategic plans, but it is not clear precisely what is being considered that might address the issues surfaced by subcommittees. Strong congruence is evident in some areas. For example, implementation of evidence-based practices, particularly for children, is evident in both the recommendations and strategic plans. Additionally, the need for accelerated research is also evident. Another strong area of congruence was the emphasis placed on independent Ombuds services for mental health. Although the MHD strategic plan does not provide any specificity as to how it will pursue this goal, the direction is clearly stated, and consistent with the Adult Consumer Subcommittee recommendation. In general, there is greater congruence with regard to children's issues than there is for adult consumer service issues.

These gaps exist in part due to the vagueness of state agency strategic plans. Notable among these are criminal justice interventions. Subcommittees identified broad goals. Task Groups defined specific strategies. Existing strategic plans are non-committal in terms of specific activities to be pursued. The same is true for supporting recovery-oriented, and consumer run services. While clearly identified as desirable goals, some state agencies do not appear to be advocating this approach yet.

Other notable gaps include older adult issues identified by subcommittees and in the co-occurring disorders (COD) goals. The strategic plans of ADSA, DASA and MHD stress activities related to the CODIAC Committee and annual COD conference.

While these efforts are positive steps in the right direction, it is unclear whether the recommendations from the subcommittees and task groups will emanate from the efforts described in the strategic plans.

Strategic plans as currently written are often general, and for the most part, do not reflect much in the way of interagency goals, objectives, and cross systems planning to allow meaningful progress towards the identified subcommittee outcomes to occur. Future planning efforts need to be more specific and concise, and engage multiple agencies working in unison to achieve tangible progress regarding many of the recommendations of the subcommittees.

SECTION 6:
Federal New Freedom
Commission Goal #6

FEDERAL
RECOMMENDATIONS

The Transformation
Work Group has
provided the Task
group with guidance
and direction to explore
technology options

Consumer Privacy will
be a paramount
concern in system
development

Technology Is Used to Access Mental Health
Care and Information.

6.1 Use health technology and telehealth to improve access and coordination of mental health care, especially for Americans in remote areas or in underserved populations.

6.2 Develop and implement integrated electronic health record and personal health information systems.

As part of the Transformation Project, the Transformation Work Group (TWG) created the Information Technology (IT) Task Group to develop strategies for transforming the state's mental health system in Washington State.

The objective of the IT Task Group was to develop specific strategies for achieving the TWG's approved outcomes. More specifically, the TWG guided the task group to develop strategies that support linked and/or integrated data across systems. Further, the state will continue to explore ways to make available to individual consumers data from their encounters with multiple providers and make that data available to the consumer's multiple providers and case managers. The goal is to make these data available "on the ground" in "real time." The TWG believes this should be a systemic approach that includes all state systems, and should not be limited to only mental health related systems.

Pursuing strategies that would further this concept would necessarily include systems that contain data related to specific individuals, therefore it is even more critical that impacts on consumer privacy and consent be thoroughly addressed. Particular attention should also be given to the relative costs and benefits of each specific strategy.

Consumer input will be a long-term requirement to improving data and technology options

**IT Task Group
Recommended
Strategies**

All of the IT strategies will require consumer input and continuing design work. Key issues include:

- Protecting privacy for individual consumers while still facilitating integrated service provision.
- Reviewing contents of websites, screens and reports to be sure they are useful to consumers, providers and managers.
- Reviewing performance measures, outcomes, and evaluation plans: *Are they really measuring what they should?*
- Reviewing websites and reports for accessibility to persons with disabilities, for needed translations, and to be sure that the content is inclusive and respectful.
- Developing vision for continuing directions.

The following strategies were defined by the MHTP IT Task Group in response to Presidential Goal #6.

1. Develop and pilot a consumer-focused, customer driven, recovery focused needs assessment screening tool for mental health and alcohol/drugs that can be used across multiple settings.
2. Develop a website for each consumer that contains an assessment tool and its accompanying recovery goals, which change over time, and can be accessed if consumer gives permission.
 - Expand existing cross-agency outcome database to each consumer receiving public or charity funded health, mental health or alcohol/drug services from any local or state agency, jail, prison or hospital.
 - Include outcomes drawn from public records of important life and recovery issues (such as employments, arrests, graduations, hospitalizations, and marriages).
3. Develop and pilot consistent survey measures for those outcomes that cannot be gathered from existing agency records.
4. Develop and pilot a Smart ID Card and associated Consumer Hub database, and link it to agency databases so they automatically draw demographic and geographic information from the

Consumer Hub.

5. Develop “spaces” on consumer website to record consumer needs and diagnoses centrally and link those spaces to each legacy website to automatically copy fields containing assessments and diagnoses into the consumer website.
6. Develop consumer “spaces” to record shared cases and link those spaces to each legacy system to automatically copy fields containing case manager actions into the consumer website.
7. Develop “spaces” on the consumer website to record prescription medications centrally, and link those spaces to each legacy website to automatically copy fields containing prescriptions, along with dates, into the consumer website.
8. Extend the DSHS Client Services Database tables to all public and charity-funded consumers (persons receiving health, mental health or alcohol/drug services from any local or state agency, jail, prison or hospital). Use monthly or quarterly extracts from each source to add consumers, services, dates and costs (paid and imputed from the encounter data). Verify results with sources.
9. Use the Outcome Database, adjusted for differences between treatment and comparison groups using the assessment and diagnostic information from Strategy 5. Publish reports, whenever possible, that distinguish outcomes by subgroup – demographic, ethnic, geographic.
10. Use the Outcome Database to monitor client outcomes resulting from services received from various MH and AOD treatment providers. Adjust for differences in populations served using the assessment and diagnostic information.
11. Develop quality assurance websites for the providers in each local area, reporting outcomes for different types of consumers.
12. On an ongoing basis, monitor the fidelity to care standards of new and expanding mental health services. Report by provider.
13. Develop a training and quality assurance database on selected evidenced-based practices.

14. Develop a data table comparing service need to service use and service supply over time. Could easily be generated for government funded consumers from the expanded consumer database and the needs assessment database for consumers generated in previous strategies.
 - Use the data table to produce tables and maps for each local area showing the “supply” of providers in relation to the “demand” from the consumer-driven needs assessments (“Supply Rate”). This will allow local communities to decide what “fill in the gap” services might be useful.
 - Use the same table to develop performance measures saying what proportion of consumers “got” the services they needed.
15. Develop the website and define a process for choosing and refining content; develop and update the general content.
16. Develop maps and directories of service providers by specialty area. Include the private providers. Generate lists from licensing databases, expanded 911 lines, crisis and referral databases and other frequently updated directors. Allow providers to self-refer to the lists, with references.
17. Provide on-line training on psychiatric rehabilitation and other topics for families, consumers and others in the community. Track both on-line and in-person usage of that training.
18. Require consumer-run services to enter persons served, frequency and dates of services. Best method might be a website using an ID card, or a web-accessible database.
19. Develop an on-line “registration” form for consumer-run services and groups. Develop a webpage displaying services on the mental health website.
20. Cost out various alternatives for charging services; choose one, and implement it.
21. Be sure that the common screening and assessment tool include the date the service need is identified and application is made.
22. Develop on-line training materials. Make sure they

**Agency and Partner
Strategic Directions**

*DSHS, Division of Alcohol
and Substance Abuse
(DASA)*

*DSHS, Health and
Recovery Services
Administration (HRSA)*

Reprocurement Of The
Medicaid Management
Information System

Outpatient Prospective
Payment System (OPPS)

are accessible by persons with visual disabilities, and translated into multiple languages. Training materials should include tests of what has been learned as the training progresses. Those tests should be recorded.

The following objectives and supporting activities and measures related to Federal Goal #6 are defined in state agency strategic plans recently submitted to Governor Gregoire.

The DSHS Division of Alcohol and Substance Abuse (DASA) utilizes a variety of web-based applications for data collection and data analysis including conducting research using administrative databases (mental health, Medicaid, employment, criminal justices and others).

The Health and Recovery Services Administration (HRSA) plans to maximize use of technology to take advantage of online services, such as electronic enrollment, eligibility reviews and client communication while safeguarding client privacy. Three specific projects are underway that highlight HRSA's efforts.

HRSA has begun the process of re-procuring its legacy Medicaid Management Information System (MMIS), which is currently the main payment system for medical assistance programs as well as other Medicaid-funded services. As envisioned, the new MMIS will assume more payment responsibility within the agency, handling all medical services (both Medicaid and non-Medicaid) as well as those non-medical programs determined to be compatible to MMIS and its new capacities. The MMIS design improvements will also include reporting and decision support capabilities as well as expand into new areas of utilization and accountability, helping DSHS operate more efficiently and effectively than before. In this new role, MMIS will become less of an HRSA system and more of the basic DSHS payer and payment information system.

HRSA is modeling the Outpatient Prospective Payment System (OPPS) along the lines of a DRG (Diagnostic Related Groupings) reimbursement structure that would apply to outpatient services. The new system, which will be phased in, will decrease the amount of cost-based payments and replace them with payments based on the actual treatment

Emergency Room And
Access Research

and services provided. Because the same methodology is already used by Medicare, the Health Care Authority and Labor & Industries, the new system also offers some consistency to providers.

HRSA has formed a workgroup to begin regular reports and data analyses on provider-access data, including client utilization of Emergency Rooms. Initial reports show that more providers have signed up with HRSA today – refuting rumors of a physician exodus from the program. But other patterns are disturbing – the additional physicians are not keeping pace with the increasing caseload, and Emergency Room utilization is on the increase. Ultimately, this research will provide HRSA with a more efficient grasp of access, give providers guidance on patient-access concerns, and offer clients better health outcomes.

*DSHS, Mental Health
Division (MHD)*

As a result of participation in the 16-state pilot Indicator Project and the 2001 Joint Legislative Audit and Review Committee (JLARC) report, the MHD has moved toward a performance and outcome-based system rather than one that emphasizes process. To prepare for this change, the division, RSNs, and providers spent considerable time updating and revising data reporting requirements and guidelines. The BBA of 1997 has also placed a heavy emphasis on the use of data for management and quality improvement activities.

- Use health technology and telehealth to improve access and coordination of mental health care, especially for consumers in remote areas or in underserved populations.
- Survey the mental health community for current uses of health technology and telehealth.
- Continue to support RSN videoconferencing to enhance consumer and stakeholder meeting capabilities, specialty consultations, and remote site access to care and services.
- Explore financial aspects of telehealth use, and coordinating traditional health and telehealth visits.

Develop and implement integrated electronic health record and personal health information systems.

- Survey the mental health community for current

*DSHS Juvenile
Rehabilitation
Administration (JRA)*

use of electronic health records and personal health information systems.

- Continue to support the implementation of the integrated state hospital information system.
- Continue to support the implementation of a person-centered, integrated, comprehensive electronic health record at all state facilities and community mental health agencies.

JRA is responsible for juvenile institutions, group homes and local parole. JRA also funds county juvenile court and detention services. The agencies Client Activity Tracking System (CATS) is a technology supporting effective case management and service provision for youth in their care. The Strategic plan action calls for full implementation of this model.

*Department of Health
(DOH)*

The DOH strategic plan requires use of data to inform the public and design public health programs.

*Department of Veterans
Affairs (WDVA)*

The War Trauma/PTSD Outpatient Program is customer and referral agent accessible from the agency webpage. This site is cross-referenced with many other national and in-state links allowing ease of electronic access. Many veterans and family members find our mental health counseling services through our webpage. Email is used in a HIPAA safe manner to offer information that will lead to information and referral. The webpage offers many informational and educational resources that would assist the treatment seeking veteran or family member find direct information and services, such as all of the WDVA PTSD Program contractors, the federal VA Medical Centers, and all other VA clinics and resources in Washington State. Additionally, other links permit direct access to the world's largest PTSD and war trauma reaction professional library, where a user friendly search offer's solid information about PTSD and other mental health issues. Email traffic within the PTSD Program is monitored daily, even on holidays and weekends, when individuals might be most troubled by their concerns and readjustment needs.

The agency offers a host of other informational resources that would act to help stabilize the life of any veteran and family members. This includes information about benefits and placement of veterans

Transformation Grant Activities

in one of the WDVA Veterans Homes. Emergency care through the VA Medical Centers can also be found as the customer or referring professional accesses the cross-referenced federal sites. This includes access to federal VA emergency mental health services and hospitalization contact numbers and locations of services.

The Transformation Project has funded a project to integrate administration databases from multiple organizations (MHD, DASA, criminal justice and employment). This integrated database will be used for multiple purposes including tracking outcomes. The project has also funded the MHD to improve capabilities of the state to report on the SAMHSA National Outcome Measures (NOMS).

There are several Regional Support Networks who have begun development on electronic health records and project staff are following their progress. The team is also working with a statewide group with representatives from DOC, the courts, local jails, and key legislators to develop electronic health records for those organizations. The TWG has also recommended that Transformation staff follow the progress of the Health Care Authority as they are the Governor's designated lead on developing electronic health records.

Gap Analysis

Although the project is involved with multiple agencies in utilizing technology to document services and track outcomes, little has been done this first year around the telehealth strategies.

Next Steps – Year 2-5

When considering strategies related to integration of data across systems, particular attention should be given to the relative costs and benefits of each specific strategy, and to the impacts on consumer privacy. The TWG requested that the IT Task Group conduct a high-level assessment of their strategies to determine costs, resources, and implementation timelines. The Task Group should focus their assessment on those strategies they believe are the most feasible.

In addition to developing integrated databases for outcome tracking and potentially in cross agency efforts to develop electronic health records, we plan to pursue telehealth strategies in Year 2.

**SECTION 7:
Washington State
Goal #7**

**Washington Believes
Stable Housing
Opportunities is Critical
to Transformation**

**Subcommittee
Recommended
Outcomes**

*Homelessness
Subcommittee*

Key Informant Outcomes

Individuals with mental illnesses have stable housing in the communities where they live.

Washington consumers have identified housing as a key component to successfully managing their mental illness. However, the lack of stable housing, including the lack of support systems to maintain housing, was a key finding in Washington's Resources Inventory and Needs Assessment (See Appendix 2). Consumers also reported problems stemming from the length of time it currently takes for a person to obtain subsidized housing. Reportedly, it can take many months before a person becomes eligible for subsidized housing.

As a result Transformation Project staff asked key informants to provide recommendations for improving stable housing options for consumers.

The following outcomes were recommended by TWG subcommittees to address housing-related improvements.

1. Housing will be available immediately upon need for individuals/families.
2. Continuation of services after a person has passed the crisis or transitional point (to avoid services and/or housing ending after a person is stable, decompensating back into homelessness).
1. People with mental illnesses have stable housing and employment opportunities in the communities where they live.
2. Increased availability/production of affordable housing, with appropriate supporting services for people with mental illnesses, throughout the state.
3. Improved discharge planning from state institutions to eliminate the release of people with mental illnesses without stable housing and supportive services in place.

**Task Group
Recommended
Strategies**

Key Informant Strategies

*Evidence-Based/
Promising/Emerging
Practices Task Group*

The following strategies were recommended by TWG task groups to address housing-related improvements.

1. Improved linkage of housing, employment, and treatment policies and resources at the state level including integration with mental health legislative initiatives related to state hospital usage and development of community-based alternatives.
 2. Provide incentives at the RSN/community/provider level to promote and fund more supportive housing.
 3. Improve data collection to track the housing status of all clients receiving services through DSHS, DOC, DOH, and/or CTED.
-
1. Programs are developed for youth and young adults that are developmentally appropriate and meet the unique, individualized needs of this population. Such models should include access to and availability of comprehensive support services including mental health, substance abuse, independent living skills, and vocational training are provided to assist youth and young adults in maintaining housing (Local examples –Youth Care Model, Mockingbird Family Model programs).
 2. Establish Housing First: Large investment in development of enough permanent subsidized housing to meet the needs of all homeless people with mental illness. Appropriate supportive services need to be attached to housing.
 3. Establish some transitional housing options to provide for overflow need.
 4. Make needed mental health and general community support services immediately available to those requiring assistance in process of stabilizing while entitlements are pursued.

**Agency and Partner
Strategic Directions**

*DSHS, Division of Alcohol
and Substance Abuse
(DASA)*

The following objectives and supporting activities and measures related to State Goal #7 are defined in state agency strategic plans recently submitted to Governor Gregoire.

The DSHS Division of Alcohol and Substance Abuse (DASA) funds and/or supports a variety of housing programs such as the Oxford House and other transitional housing. This includes specialized housing for men, women, and pregnant or parenting women. DASA also works with local government and providers to team up with housing organizations to increase the types of housing available to chemically dependent individuals.

*DSHS, Mental Health
Division (MHD)*

The DSHS, Mental Health Division is the contracting agent for local-level services provided through RSNs. With regard to residential and housing services, Chapter 71.24 RCW requires that RSNs ensure:

- Active promotion of access to and choice in safe and affordable independent housing that is appropriate to the consumer's age, culture, and residential needs.
- Provision of services to families of eligible people who are homeless or at imminent risk of becoming homeless, as defined in Public Law 100-77, through outreach, engagement, and coordination or linkage of services with shelter and housing.
- The availability of community support services, with an emphasis on supporting consumers in their own home or where they live in the community, with residences and residential supports prescribed in the consumer's treatment plan. This includes a full range of residential services as required in Chapter 71.24 RCW.

*Department of
Community, Trade, and
Economic Development
(CTED)*

CTED provides a variety of programs focused mostly on community development activities, but including housing and employment supports. The community mobilization program supports communities in preventing the impacts of substance abuse. In addition they provide mental health services through the Crime Victims program. CTED's strategic plan identifies an important strategic initiative:

Interagency coordination of homeless programs to support effective provision of housing. A goal of this initiative is to improve the lives of homeless

*Department of Corrections
(DOC)*

*Department of Veterans
Affairs (WDVA)*

**Transformation Grant
Activities**

Gap Analysis

individuals and maximize resources by providing increased coordination and reducing the fragmentation of housing services. In 2006 the state created the Interagency Council on Homelessness in response to the 2005 legislative requirement to reduce homelessness in Washington State by 50%.

DOC will assist offenders in connecting with housing services.

WDVA has for many years offered homeless outreach to troubled veterans and families. This has taken many forms and has worked with target populations to include rural, urban, and women veterans. Joblessness has also been the focus on other subprograms. In all cases the mental health status of each individual has been the concern when placements are accomplished. The War Trauma/PTSD Program has long worked with those who are homeless, or who have a high potential for homelessness. Forty percent of homeless are thought to be veterans, and a very high percentage of this group also suffers significant mental health related problems. WDVA is working to create a specialized program that will house, treat, and train homeless veterans within the next year. In conjunction with the federal VA, these services will act to address to a greater degree the needs of this population

As part of the transformation process, Washington State is exploring additional opportunities to expand stable housing for consumers and their families. For example, Transformation Grant staff are collaborating with other Washington stakeholders to end homelessness and create employment opportunities for individuals who are homeless and also experiencing mental illness. These initiatives include "Taking Health Care Home" which is located in King County and administered by the City of Seattle, in collaboration with the Divisions of Vocational Rehabilitation and Developmental Disabilities, providers, RSNs, members of the private sector such as developers, and other key housing and employment stakeholders.

Housing issues are intimately tied to issues of employment. Efforts to create jobs for consumers, as well as families and youth, both within the existing service delivery system and complementary to it, cannot succeed without the recognition of this

Next Steps – Year 2-5

relationship. In addition, implementation of the CMHP outcomes and strategies will require that non-traditional partners (e.g., ESD, CTED) become engaged throughout the process and coordination efforts be expanded. This coordination should focus on increasing efforts to reduce stigma for individuals with mental illness who seek both housing and employment as part of their recovery. This effort will also be coordinated with the MHTP's Social Marketing Campaign and Workforce Development initiatives.

While many state agencies have identified housing as an area in need of policy attention, additional cross-agency coordination is needed to identify specific projects for future implementation.

Many counties are developing strategies to end homelessness in ten years. This is a national movement. The Transformation Project has been in contact with several statewide homelessness and housing committees and will work toward creating collaborative strategies in Year 2.

**SECTION 8:
Washington State
Goal #8**

**Washington Believes
Improving Employment
Opportunities and
Outcomes is Critical to
Transformation**

**Employment is an expectation and a priority in
Washington for people with mental illness.**

Key findings from Washington's Resources Inventory And Needs Assessment (see Appendix 2) clearly articulate several consumer concerns regarding opportunities for consumers to obtain and sustain employment.

- Most consumers do not believe that mental health services help them get basic resources such as employment and safe housing – services are not seen as helping them gain independence.
- Almost half of the respondents reported they are seldom, rarely or never supported in getting the education and guidance they and their families need to be fully supported.
- Most respondents (57%) reported that they have never been helped by mental health services to get or keep employment.
- Only 13% of all respondents reported being employed.

As a result, the Transformation Project staff asked key informants to provide recommendations for improving employment opportunities and outcomes. These individuals developed their recommendations based two guiding principles:

1. We believe in the value of work at the earliest stages of recovery, as an aid to the recovery process.
2. We recognize that employment can help people develop motivation to change, promote dignity and self-respect, and instill hope for the future.

**Subcommittee
Recommended
Outcomes**

*Adult Consumers and
Families Subcommittee*

The following outcomes were recommended to address employment-related improvements. A complete list of strategies and outcomes is included in Appendix 3.

1. Consumers have access to evidence-based vocational rehabilitation services on demand that include high quality, supported employment based on national standards. These programs work collaboratively with Division of Vocational Rehabilitation (DVR) to ensure employment for as many consumers as possible.

Key Informant Outcomes

1. People with mental illness are successful in getting and keeping employment in the community where they live.
2. Increased availability of targeted employment-related resources, supports and services for people with mental illness throughout the state

**Task Group
Recommended
Strategies**

Key Informant Strategies

The following strategies were recommended by the task groups to address employment-related improvements.

1. Improved linkage of employment policies and resources at the state level with the Mental Health Division and the Division of Vocational Rehabilitation jointly responsible for alignment, leveraging and accountability.
2. Incentives at the RSN/community/provider level to promote and fund supported employment as an evidence-based practice.
3. Improved data collection to track the employment outcomes for mental health customers who utilize DVR, Clubhouses, WorkSource and other employment related resources.
4. The Mental Health Division, Division of Vocational Rehabilitation, RSNs, and Consumer Organizations will jointly sponsor statewide and local working groups comprised of a majority of employers to identify/implement specific strategies and activities that result in increased employment opportunities for consumers.
5. Increase employment activities.

*Evidence-Based/
Promising/Emerging
Practices Task Group*

6. RSNs and Community Mental Health Professionals will deliver therapeutic services that increase a consumer's resiliency in a work setting and supports the individual in getting and keeping a job, based on a model that recognizes employment as an essential element of recovery.
7. Community Mental Health Services will include specific activities that enable consumers to maintain long term stability on the job, including activities that assist employers in supporting consumers on their jobs.
1. The MHD will pilot two self-directed care programs, one in Eastern Washington and one in Western Washington, based on the Florida SDC Model.
 - Consumers in this program will be paired with a trained life coach who will act as a brokerage support to assist in the overall design and management of their self-directed care plans.
 - Consumers in this program will be eligible to purchase services for the purpose of accessing:
 - Supported Employment.
 - Recovery support services (services that are alternative to traditional mental health services) such as:
 - Services related to developing employability and/or productivity that will lead to employability.
2. Use individual placement and support.
3. Use assertive community treatment with employment component.
4. Provide supported employment and clubhouse-based transitional employment.
5. Use peer support, WRAP, clubhouse, and supported education as a way to maintain recovery and retain employment.
6. Cross train vocational rehabilitation staff and clinical and vocational mental health staff to increase integration and communication.

**Agency and Partner
Strategic Directions**

*DSHS, Aging and
Disability Services
Administration (ADSA)*

*DSHS, Division of
Vocational Rehabilitation
(DVR)*

*DSHS, Division of Alcohol
and Substance Abuse
(DASA)*

*DSHS, Mental Health
Division (MHD)*

7. Provide support for consumer-owned and operated businesses.

The following objectives and supporting activities and measures related to State Goal #8 are defined in state agency strategic plans recently submitted to Governor Gregoire.

ADSA plans to implement the Working Age Adult policy for developmental disability clients. This policy relates to providing eligible clients with employment programs, clients with co-occurring mental illness.

DVR will adopt methods, rules and policies that create equitable access to services for individuals with all types of disabilities.

DVR will develop counselor skills serve individuals with the most significant barriers to employment. They will modify service provider contracts to allow more flexible, outcome-based and cost effective services. DVR will work with the Mental Health Division (MHD) to develop a supported employment program as well as a strategy for sustaining clubhouse models.

DASA encourages strong connections between providers, vocational employment organizations and local government in order to improve client employment outcomes. A collaborative effort between local Temporary Assistance for Needy Families (TANF) offices and the chemical dependency systems has resulted in the co-location of counselors in the TANF office to screen clients and refer to treatment as needed so that their dependency is not a barrier to obtaining or sustaining employment. DASA also monitors employment outcomes of all treatment clients utilizing administrative databases.

RSNs and PIHPs coordinate with rehabilitation and employment services to assure that consumers wanting to work are provided with employment services; to assist consumers to achieve the goals stated in his/her individualized service plan; and to provide access to employment opportunities, including:

- A vocational assessment of work history, skills, training, education, and personal career goals;
- Information about how employment will affect

income and benefits the consumer is receiving because of their disability;

- Active involvement with consumers served in creating and revising individualized job and career development plans;
- Assistance in locating employment opportunities consistent with the consumer's skills, goals, and interests;
- Integrated supported employment, including outreach/job coaching and support in a normalized or integrated work site, if required; and
- Interaction with the consumer's employer to support stable employment and advise about reasonable accommodation in keeping with the Americans with Disabilities Act (ADA) of 1990, and the Washington State Anti-Discrimination Law.

The Mental Health Division is a primary party to the Medicaid Infrastructure Grant that has a focus on consumer recovery, and has included the following actions, accounted for in annual reports to the public and to the MHPAC:

- Numerous trainings statewide on Healthcare for Workers with Disabilities and Ticket to Work;
- Seven "Pathways to Employment" conferences held throughout the state which provide information on employment-related programs, housing, transportation, social security benefits and other information related to recovery;
- Employment track offered at the annual Behavioral Health Conference held each June;
- Twenty conference scholarships awarded to consumers involved with employment-related programs;
- Ongoing collaboration with other DSHS partners in order to increase the infrastructure of employment-related supports for persons with disabilities;
- Membership on the advisory board for the Center for Continuing Education on Rehabilitation;
- Continued funding expected for one FTE in 2005;

	and
<i>DSHS Juvenile Rehabilitation Administration (JRA)</i>	<ul style="list-style-type: none"> Continued funding is expected to initiate an Enhanced Peer Support Training module, offered in addition to the 40-hour required training for certification. <p>JRA is responsible for juvenile institutions, group homes and local parole. JRA also funds county juvenile court and detention services. JRA strategic planning calls for expanding and strengthening education and vocational programs throughout the juvenile systems continuum of care.</p>
<i>Department of Community, Trade, and Economic Development (CTED)</i>	<p>CTED provides a variety of programs focused mostly on community development activities, but including housing and employment supports. The community mobilization program supports communities in preventing the impacts of substance abuse. In addition they provide mental health services through the Crime Victims program. Through local economic development councils, CTED is responsible for linking WorkFirst clients to employment opportunities. CTED recognizes the need to serve disabled and vulnerable populations; however, it remains unclear if mentally ill individuals are effectively identified for supported services in locating and keeping employment through this program.</p>
<i>Department of Corrections (DOC)</i>	<p>DOC will assist offenders in connecting with employment services.</p>
<i>Employment Security Department (ESD)</i>	<p>ESD will develop processes and methods to identify individuals who need WorkSource assistance most and increase job placement services to them. This includes individuals with disabilities who lack the education or training to compete for good jobs.</p> <p>To accomplish this task, the Transformation Project staff will need to work with ESD as they improve their assessment process to identify persons who have mental illness and require additional support services in order to become employed.</p>
<i>Department of Veterans Affairs (WDVA)</i>	<p>WDVA is working to create a residential transitional program currently being planned to open on the Retsil Veteran Home campus next year. This unique program will train and place disabled veterans in jobs, while also helping them return to community life. This program borrows from successful models that have worked with similar populations by</p>

creating stability, consistency, safety, and sufficient time and treatment/support, to endure attempts to resume participation in gainful employment. The federal VA is a partner in this new program, one that will offer great hope for our troubled war veterans.

WDVA also offers a program that resulted from recent state legislature efforts. This specific effort is aimed at helping war disabled veterans return to active connections within the world of work. The Veteran Conservation Corps (VCC) has already created dozens of opportunities for disabled veterans, particularly those with war-related Post Traumatic Stress Disorder (PTSD), to work within their community on wildlife projects, most notably, salmon habitat restoration. Guided by an experienced contract wildlife biologist and former PTSD treatment provider, veterans are placed in stream, estuary, and coastal tideland restoration activities that are designed to allow the veteran to participate constructively in the work of restoring salmon runs and related critical environments. Over the next few months these activities will be enhanced when six placement coordinators situated around the state begin placing veterans into restoration work sites. Connections with various state and federal agencies, private funding resources, and organizations dedicated to restoration efforts, is allowing previously fully disabled and socially disconnected veterans an opportunity to return to healthy occupational experiences. For many of these very traumatized warriors, this is often the first time they have been able to offer something to their communities and at the same time see the products of their efforts. The results their hard work, often stands in direct contrast to what these veteran might believe and remember about the combatant lives. Performing in this way, allows for a renewal of who they are and their potential for benefit to the community.

**Transformation Grant
Activities**

Gap Analysis

Next Steps – Year 2-5

As part of the transformation process, Washington State is exploring additional opportunities to expand employment related activities for consumers.

While many state agencies have identified stable employment as necessary for an individual to achieve recovery, few of these agencies have delineated clear strategies for accomplishing this.

As mentioned in Goal #7, all effort to increase employment opportunities will be coordinated with our partners to ensure that activities related to both housing and employment are considered together.

The MHTP Project is already engaged in crafting a Workforce Development Plan aimed at both expanding the current mental health workforce in alignment with SAMHSA's efforts (as laid out in the DRAFT National Action Plan developed by the Annapolis Coalition) and expanding the number of consumers, family members and youth employed in delivering mental health services in Washington.

In Year 2, we will facilitate cross-agency discussions in an effort to develop more specific recommendations and strategies regarding employment services.